/24/20Clinical Observation. Art of Doctoring 2019-20

Most recently, I was on a primary care sports medicine rotation. For two weeks, I was in a clinic with family med doctors who specialized in sports medicine as we saw patients with complaints ranging from torn rotator cuffs to severe knee arthritis. One patient we saw was an elderly female in her 90s. She had seen the doctor I was working with for the first time about a year prior and, since then, had been coming in every three months for evaluation of her severe bilateral knee arthritis. She had received several knee steroid and lubricant injections to no avail. She was extremely healthy otherwise as well. She took only multivitamins and maintained her hobbies of knitting and bingo. She had tried everything and was finding minimal relief from expensive CBD oil she would rub into her knees. Unfortunately, her knees were causing her a lot of discomfort and, due to her age, she was no longer a candidate for knee replacement which would be her only definitive cure. Our encounter with her stuck out to me because I saw just how debilitating something as common as arthritis could be. H

ere was an otherwise healthy elderly female who was trying her best to maintain her lifestyle but was being held back due to her knees. Had she come in a few years prior, she would have been a candidate for knee replacement. I felt incredibly sorry for this patient. She was so kind and wouldn't stop thanking the physician for trying the various injections on her despite her minimal relief. She was so grateful to him for continuing to suggest different options that could help reduce her symptoms. The physician suggested a new nerve ablation therapy that may hold some promise and the patient was ecstatic at the thought of there being some hope. He promised he'd discuss the case with his colleague who was trialing this new therapeutic technique and the patient thanked him.

In my future practice, I'll be sure to try my best to empathize with my patients and to do my best to think of all potential therapeutic modalities that are available before telling a patient we have tried everything. I'll also be sure to give patients the time they deserve just so they can vent about their symptoms which I believe has some therapeutic value in and of itself.

COMMENTS: --, some things I really liked in this essay: 1) you were really on the side of the patient, admiring her efforts toward health and fulfilling life and clearly wanting the best for her 2) you didn't give way to ageism stereotypes, but rather recognized that this healthy 90+ year old woman might have a few good years in front of her if only her knee pain could be resolved 3) you admired the attending because he was empathetic toward this "bread and butter" plight (arthritis) and continued to try to help his patient, including considering new possibilities and consulting with a colleague. In this way, he demonstrated genuine compassion in action, where his concern for the patient motivated efforts going above and beyond. 4) Finally, your point about "venting" is well-taken. When people suffer alone, their misery is intensified. When they can share their plight with another, even when they do not receive the relief they crave, the burden - and suffering - is lessened. A perfect example of a great physician role model!

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

A 3 month old baby was brought into the Emergency Department by her parents for a high fever. The resident I was working with suggested that we see the patient together. When we walked into the room, the mother immediately started sobbing. Both the parents were extremely concerned about the baby being sick. We found out that their other child, now 5 years old, had meningitis as an infant and they were worried it was something similar. The resident examined the child and then spent time answering all of the parents questions. He thoroughly explained what the workup was going to be and reassured them that she would receive the best care possible. After the lab results came back, it was determined that there needed to be a lumbar puncture to rule out meningitis. This time we went to talk to them with both the resident and attending since the parents were already very concerned. The mother was visibly upset as we explained the procedure, and expressed her concern about how painful it was and what the risks would be. The attending physician put her hand on her shoulder and validated her concerns as a mother. She spent a long time explaining in detail what the procedure would entail and the reasons the procedure was necessary. The parents left the room so we could perform the spinal tap, and they both thanked the doctors for their explanations and compassion. They said that they felt much better knowing she was in great hands.

This interaction really stood out to me because it was such a stressful time for the parents and the doctors did a wonderful job showing empathy and gaining their trust. The pediatric setting is unique in the relationship you have with parents and family members. In the Emergency Department, it is often difficult to spend quality time with patients so I appreciated that they recognized the need to take time in this situation. Showing compassion for what may be the worst day in that person's life is very important. This can be done by simply touching a patient's shoulder, or having open body language and eye contact that shows your concern. I also noticed that their tone of voice showed their concern, they tried to match how the parents were talking. They also did a great job explaining complicated medical jargon in terms that the parents could understand. Taking time to listen to all of the concerns that the patient's family has also contributes to building a solid patient-doctor relationship. It shows you care and can help with gaining trust. The attending would allow long gaps of silence, which gave time for the parents to think and come up with any questions. I hope to emulate how the doctors approached and interacted with the parents. I think it is important to humanize your patient and remember that each patient deserves your undivided attention and concern.

COMMENTS: --, what I particularly appreciated about your essay is that everything you highlighted was small, almost unnoticeable: a hand on a shoulder, a gentler tone of voice, eye contact, body language, easily understood explanations, patience and taking a little time. None of these things is enormously time-consuming, and some don't require any additional time at all, just a shift in attitude. Yet, as you astutely observed, the impact can be significant. These frightened parents (this incident clearly triggered the trauma they went through with their first child) were confused and worried when they arrived in the ED. Yet, these small actions earned their trust and allowed the patient to be appropriately evaluated. I also agree that in the ED setting, engaging in these actions can be even more challenging. But your role models showed its possible, and the rewards lie in a baby receiving the care needed and the parents feeling safe and secure about their precious child. Importantly, you were able to analyze why this difficult encounter went so well. The devil may be in the details, but so is redemption.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

The Sandwich

I am on my endocrinology rotation. We were consulted to manage type 1 diabetes with erratic blood sugars for a 22 year-old patient with borderline personality disorder. She had a history of multiple hospitalizations for DKA secondary to suicide attempts via not-taking her insulin. In the past, she frequently would bargain with and manipulate inpatient providers with regards to how much insulin she would take and how much of her meal she would eat, as well as how many snacks she would eat (the general rule is if you take insulin you need to eat or your blood sugar can crash and you can die, and if you eat you should take scheduled/spaced-out insulin so your blood sugar does not spike). She would also steal snacks from other patients and steal ID wrist bands from other patients in order to get extra meals. It was difficult to manage her blood glucose.

This kind of manipulative, self-destructive behavior can be fairly typical of patients with Borderline Personality Disorder in the inpatient setting as it is often a form of acting out in an attempt to gain control and validation in a situation in which they have little control and may feel little validation. These patients will often "split" on their providers (either love them or hate them) and thus create discord among members of the healthcare team. From past experiences, I knew that often times the best psychiatric care for a patient with borderline personality disorder is to get them out of the inpatient setting. This patient had had a habit of staying at the hospital for about a month at a time. On the other hand, people labeled with the diagnosis of borderline personality disorder in their chart often get worse medical treatment and end up with poorer health outcomes due to the stigma of the disease.

Currently, the primary team did not have her on any prandial insulin and were worried about her erratic blood sugars. Whether they were aware that you cannot have stable blood sugars without prandial insulin or whether they were just afraid to give insulin to someone who might manipulate the situation and cause hypoglycemia or DKA again, I am not sure. Fortunately, this endocrinology team was well acquainted with this patient and had already formulated a previously successful, novel plan of creating a sliding scale prandial dosage of insulin titrated based on what percentage of food the patient ate at each meal (no prandial insulin would be added for snacks). It seemed simple to just stick to that plan as long as we maintained a unified front as a healthcare team.

When I saw her, she told me she was taking a ridiculous amount of insulin each meal (either absurdly high or no insulin). As I was warned beforehand, I felt I could not trust much of what she told me. While she had told her psychiatrists that she had no suicidal ideation, I suspected that she was telling me false insulin dosages so I would repeat the orders and cause disastrous sequelae. Furthermore, the patient said she was "starving," that she needed more snacks throughout the day. Currently she had one, a half of a tuna sandwich at bedtime. Or, she offered, she would be willing to give up her only snack for an increase in caloric content in her meals. She said that she normally has a large appetite and that it was the same here. Looking at her, I could see that puberty had been stunted for her. My guess is that by not taking regular, scheduled insulin, she had deprived her body of its opportunity to grow during puberty, and thus had the body of a much younger girl. I also suspected that her large appetite was due to lack of insulin in her body. Insulin triggers the release of Leptin, the body's hormone signaling Satiety. I also suspected the antipsychotic, Ziprasidone, she was on was contributing to some insulin-resistance which might be contributing to her increased appetite.

When I spoke to the Endocrinology Fellow, he more or less agreed with my plan. When I brought up the possibility of eliminating snacks for meals of greater caloric content, he said that we should avoid adjusting her meal plan while adjusting her insulin for the sake of controlling variables and said that he did not trust her motives regarding her latest bargaining over food. The attending listened and said nothing. I also offered my theories regarding the relationship between the patient's low insulin and increased appetite, as well as the relationship between her ziprasidone and possible insulin resistance. The attending and the fellow didn't disagree, but neither did they wholeheartedly agree.

The attending and I went to see the patient while the fellow went to see another patient. I relayed the plan to the patient, explaining that we did not want to adjust her food schedule while simultaneously altering her insulin regimen. I conjectured to her that I thought her satiety would improve once she was on a more regular regimen of insulin. She was not satisfied and looked to the attending. The attending squirmed and said, "We will see if we can add a mid-morning snack. I will ask your nurse." I stared at the attending. In my experience, when a doctor says, "I'll ask your nurse" about a decision that should be their responsibility, it usually means they are afraid to say "no" to the patient directly.

To my surprise, when we left the room, the attending said, "A mid-morning snack should be ok," and told me to confirm with my fellow before confirming the plan with the patient. Just as we turned to leave the locked inpatient unit, the patient called after us, "Aren't you going to ask my nurse?" My attending went over to the patient and said something to her. I don't know what it was, but I assumed it was to tell her I would speak with the fellow. And then we parted ways.

My fellow shrugged. "A snack won't raise her glucose that much," he said. "She should be ok." I double-checked with the nurses just to make sure she wasn't manipulating the team members about when and how many snacks she was getting already, and then I told the patient, who nodded in agreement. "Does that mean I will get a snack now, because I didn't get a snack this morning?" I looked at the time. It was already mid-afternoon. I squirmed. "Ask your nurse," I said, reluctantly, knowing that the nurse would probably block the request. She nodded and I hurried out.

I had gone into this patient interaction with the goal to put up clear boundaries, set up a unified front, and give this patient with borderline personality disorder the structured framework that she needed to be kept medically stable and discharged. I had had experiences of swinging too far to the side of advocacy for patients with personality disorders to the extent that the lengths I was going to make them happy were not helpful for the patient's treatment, such as wearing the same pants they liked every day just because the patient treated me better when I wore them. On the other hand, I had also had a bad experience of putting up boundaries with a patient with borderline personality disorder when I was asked to provide resources for physician-assisted suicide.

Getting yelled at and criticized for lacking empathy when putting up boundaries is no fun and makes one question themselves and their qualifications to be in medicine. I did not like the way my attending squirmed and broke from the lines of our unified front to give in about the sandwich, just like I did not like the way we both deferred to the nurse for decisions we did not want to make in front of the patient. But sometimes a sandwich is just a sandwich. There is a reason patients with borderline personality disorder get worse care in the hospital, and differentiating between disagreements of little to no consequence and disagreements of large consequence is important. On the other hand, sometimes a sandwich is not just a sandwich, but a representation of a lack of structure that a patient greatly needs.

I once interviewed for a job as an ABA Therapist, and when asked what I would do if a child I was teaching was demanding a cookie, I said, to my interviewer's disappointment, that if it was just a cookie, I would give them a cookie. Looking back on it, I can see that for a kid with autism, a cookie could be a gateway for a whole host of unhealthy behaviors and medical problems growing up, and that as an ABA Therapist, it was my job to teach that kid healthful behaviors. However, this patient was not a child but an adult, and to deprive them of the sandwich made me feel like a Kindergarten teacher. Even patients have the right to mess up their blood sugar. And as long as she did not cause DKA by refusing her insulin, she would be ok. Maybe I had been transferring onto the sandwich a power struggle that wasn't there, that didn't need to be there.

As a medical student, it is easy to be caught between the opposing forces of the patient and the healthcare team, the fellow and the attending. As providers we are often sandwiched between the needs to maintain boundaries and to give the patient what they want. In diabetes care, and really all of medicine, negotiation is important, from motivational interviewing to harm reduction. Sometimes, effective care can germinate only from compromise. And only through hindsight do we frequently know the result of our diplomacy attempts. Until then, we have to get used to being the tuna to a highly prized sandwich.

COMMENTS: Haha, great conclusion, Tuna :-). This is an exceptionally thoughtful essay, --, that plumbs some of the tensions and contradictions in medicine, particularly as a medical student. The essential dilemma as you define it is the phenomenaon of being caught in the middle, between boundary-setting and accommodation, between patients and residents/attendings. Although these tensions may be most acute in medical school, I don't think they ever entirely disappear. Experience and practice can help you find the appropriate negotiating line with patients; and can also help you know when it's important to advocate for patients within your institution or in the larger society and when "doing what the patient wants" is actually not in their self-interest. So wrestling with them is good practice!

I think your analysis of BPD and its management is quite accurate. Boundaries and especially a unified front are essential in containing the more destructive tendencies of a patient with borderline personality disorder. I don't know enough to comment on the advisability of the snack. However, what sounded like a spontaneous, perhaps not carefully considered decision on the part of the attending seems to risk undermining the concept of all members of the treating team holding the line. Discussing and determining this course of action beforehand might have been more effective in addressing the patient's borderline issues. From the attending's action, the patient may have concluded that pleading and other strategies would be successful in the future in getting what she wanted.

You also have an important insight about the risks of implying that the nurse has responsibility for decisions that really fall within the purview of the physician. We all dislike situations in which we make a choice that may bring recriminations and blame. But of course, it is better to go in and through in these situations, no matter how difficult. In this case, suggesting another member of the team has authority which she in fact does not have is likely to lead to further splitting, as well as dissension on the team.

I wish there was a hard-and-fast rule for these sorts of negotiations, whether with patients or on behalf of patients. You are so right that sometimes a sandwich is just a sandwich and sometimes it's a lot more. Because most patients suffer from a real sense of loss of control, finding ways to restore some measure of power to them can often be very helpful in ameliorating conflict. However, a patient with BPD adds an extra level of complication.

Learning from your experience and making adjustments accordingly, as you clearly have been doing, makes great sense to me. To some extent, you will likely always be the tuna. But I think as you grow as a physician, you will find ways not to be part of a sandwich, but rather be able to swim free (or at least freer :-).

P.S. You made a very interesting point which I had not realized about the less-than-optimal care the patient with borderline characteristics can receive on an inpatient unit because of their own manipulative, splitting tendencies and because of the stigma of the condition. This is really an important awareness and I thank you for educating me about this possibility.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I was doing an away rotation and we had a patient with prostate cancer that was in remission. We got a CT scan because he was having severe abdominal pain and found a new, possibly cancerous lesion in his liver and needed to break the news. My resident went into the room, sat on the bed and discussed the findings with the patient. She spoke very calmly and went straight to the point. She stated that there was a lesion seen on the CT in the liver and that we did not have information about what this could be, but then proceeded to list several possibilities including cancer. She was very brief in her initial description and let the patient ask many questions that she answered honestly, confidently, and kindly. The patient had been through a cancer diagnosis already, and the thought of having a new unrelated cancer in his liver was devastating to him, especially since he thought he had beat his prostate cancer. He was angry and frustrated but my resident remained calm and compassionate.

To this day, I try to model myself after this resident. She really listened to her patient and took the time to be available for all questions. She showed concern, compassion, and was humble. She explained things in easy to understand terms and was not afraid to tell the patient cancer was a possibility despite not having definitive evidence. I think this was important to present the patient with all options and not sugar-coat the findings. She showed true integrity and respect.

COMMENTS: --, this encounter does indeed sound memorable. Your resident modeled important therapeutic attributes of kindness, concern, empathy and humility in a very difficult situation. In addition, she was able to be honest and forthright in conveying bad news, which for the tenderhearted can sometimes be difficult, but which is really an act of kindness for the patient. Finally, she knew how to stay calm and compassionate in the face of the patient's very understandable anger (and likely fear), knowing that his emotions were really directed at his disease, not at her. This encounter is one I'm sure you will continue to refer back to as a reminder of the importance of keeping your own emotional center so that you can focus on the needs of the patient.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I distinctly remember on the medicine wards when we were caring for a patient who was extremely difficult to communicate with. He was a cancer patient who had failed several chemotherapy regimens and, with his history of strokes in the past, had slurred speech and poor hearing. To complicate the interactions further, he had an atypical family situation. His wife was his cousin and together they had six children who all seemed a bit off. Not only was health literacy poor, these family members were poor communicators at baseline with circular logic, short-tempered, and fought amongst themselves regarding what was best for their father. This patient stayed in the hospital through the transition of attendings on my team. The contrast between how the first attending interacted with the patient and his family compared to the second attending was night and day. This is not to say that either of them interacted poorly.

The first attending remained professional but firm and a bit removed during all meetings. Not much progress was made in terms of helping the family really understand what was going on so that they could decide how to move his care forward. Thus, the patient became what the team called "a rock". Just when we thought some progress was being made and the family agreed to something, some other family member would come in and demand the completely opposite, at the same time complaining that the hospital was not doing enough for the patient. Many nurses were "fired".

When the second attending came, things were so much better. Her body language and approach to conversations are things I will try to emulate in the future. She entered every room with such warmth, asked for permission before speaking about the patient's condition, and always apologized for things the patients were upset about regardless of whether or not it was her fault in any way. She would sit down by the patient or even kneel on the floor for an hour straight if there were no chairs. The content of what she was saying was really no different from the first attending. What she did differently was how much effort she put into truly listening to the family members. Only then would she proceed to speak to the emotions behind what they were verbally saying. Despite their quarrels, what she identified and unified them with was that the one thing they shared was the fear they felt for their father. They responded to this and finally came to a decision to have him discharged home with hospice.

COMMENTS: --, this is an extremely perceptive essay. First, you make a good point that there is a continuum of reasonable physician behavior, and different circumstances call for different ways of acting. Nevertheless, as you saw in contrasting the two attendings, the second was much more effective in helping the family overcome their own interpersonal difficulties and reach a decision in the best interests of their father.

Your awareness that it was not so much what the attending said (not really much different from the first attending) as how she said it and how she listened. I loved your noticing how she would sit or even kneel, a posture of great humility and respect. I also appreciated your insight that she knew how to "speak to the emotions behind what they [the family] was saying." Listening for the message beneath the message is a very valuable skill. When you are able to say to a family member, "This is a really scary situation for you, isn't it?" rather than getting caught up in the content (the nurse didn't come immediately when we pressed the call button) it becomes much easier to address their deeper needs.

Finally, helping the family to find common ground ("the fear they felt for their father") can be a very effective way of moving beyond difference. Like listening for the emotions, this skill requires emotional intelligence, an attunement to the underlying currents that flow in such fraught and painful situations. Knowing how to "read the room" can help you cut through a lot of distracting interactions, and focus on meeting the root concerns of the family.

Really nice work, --!

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

My clinical observation occurred in the Medical ICU with an outstanding attending – one who not only is medically competent but also successful in her role as a team leader and is empathetic, communicates well, and listens to each patient.

A patient that particularly stood out to me was a 30-something year old young woman with a history of Lupus. Unfortunately, she had refractory Raynaud's – which meant she had such severe vasoconstriction of her peripheral arteries in her hands and feet that her fingers and toes began to become necrotic and start falling off. Despite several therapies with various IV vasodilators, the team failed at salvaging her fingers and toes. As the only Spanish-speaking member on the treatment team, I was able to communicate with this patient closely and directly. I'll never forget her telling me, "all I want to do is to be able to have a manicure and pedicure like a normal girl my age can" – a statement that really hit close to me as a young woman myself. I had a hard time understanding how despite all of our medical advancements, we couldn't help this patient.

The ICU team taking care of this patient included the attending physician, critical care fellow, senior resident, two interns, three medical students, social worker, case manager, nurses, and pharmacist. Each person on this team played a vital role in her care. As the medical student following this patient, I got to witness how the rest of the medical team interacted to provide this patient the best care we could.

Most notably, what I took away from this experience is learning the medical team's role in a patient's care beyond the actual medical knowledge. This patient had been tried on every vasodilator therapy without any therapeutic improvement. Yet, she was a patient in the ICU that required the support of every medical team member. I saw how the resident sat with her, listened to her frustrations and concerns, and served a role in her car far beyond solely taking care of her physical health. I saw the social worker staying by her side making sure that the patient's daughter at home was taken care of and addressing her social concerns so that she didn't have to worry about other things while in the hospital. I saw the pharmacist take the time to use the translator and explain the mechanisms of all the various drugs to the patient so that she fully understood what was going in her body, rather than just throwing medications at her.

And lastly, I saw the attending serve as the "captain of the ship", not only inside the patient's room but also during rounds as she made sure that each team member was fulfilling their respective role all for the greater goal of caring equally for the physical, emotional, and mental health of this patient.

Through this experience, I learned a lot more than they actual medicine that I will always carry with me to become a better doctor. Moving forward, I have made it a point with each and every patient to understand them in their greater social situation – not only treating the medical illness lying in the bed in front of me but rather caring for the entire person as an individual – their worries, questions, fears, and hopes. I also learned the importance of the team effort, recognizing that it is near impossible for one person to take on all these hats at once, but by collaborating and fulfilling our respective roles on the team, we can provide exponentially better care for our patients.

COMMENTS: I agree with --, it is simply heartbreaking to hear about the manicure/pedicure. What strikes me as well is your ability to recognize just how important a statement this was - not some

trivial comment, but a disclosure that spoke to the essence of who she is (a young woman who deserves the experiences that other young women relish). Your empathy is very much in evidence.

This was a great opportunity to be part of a complex yet highly functioning team, led by a "captain" who indeed sounds like the complete package, both a strong ledader and an empathic physician.. I appreciated your observation that everyone on the team has something to contribute not only medically but to the patient's overall wellbeing. One thing I particularly liked was that the "nonmedical" care was not relegated to the social worker or the medical student. Everyone recognized the ongoing tragedy and addressed it with patience, concern, and support.

--, it is so insightful to see that what patients care about is the quality of their lives, not just the nature of their disease. When you can place the patient within their life context, you are providing truly patient-centered medicine. When a whole team is doing this, rather than one physician carrying the weight, there is a multiplier effect, and the benefit to the patient is increased greatly.

I'm very glad you had this hopeful and illuminating experience.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

My clinical observation took place in an outpatient pediatric endocrinology clinic, observing the division chief, Dr. X, one afternoon. This particular clinic was a multidisciplinary MediCal clinic for children with diabetes. In addition to the endocrinologist, patients met with a nutritionist, a social worker, and a psychologist if needed. The patients seen in this clinic were extremely diverse, although all of them were of low socioeconomic background given they qualified for MediCal. The majority had type 1 diabetes, ranging from 2 years old into the teen years. There were also several children with type 2 diabetes and significant obesity.

The first thing I noticed about this clinic was how well the different disciplines worked with one another. The nutritionist, social worker, psychologist, and Dr. X all got along quite well. It was clear that these people liked one another both inside and outside the workplace. People asked about each others' loved ones and brought in baked goods from home. The clinic itself was chaotic and busy. There were a lot of patients in a small amount of time, and many of them had complicated social situations, in addition to poorly controlled diabetes. By the time every member of the team met with the patient and discussed a plan together, a good hour would have passed. In spite of this chaotic atmosphere, the clinic hummed along and somehow finished on time.

I was impressed throughout the visit with how the endocrinologist, Dr. X, treated the other members of the team as his equal, if not his superior. He often deferred to their experience, since many of the nutritionists and diabetes educators knew the patients for many years. At the same time, Dr. X was very clearly responsible for signing off on the ultimate plan. From this standpoint, he struck me as an excellent manager. He let his "people" run the show, because they are competent and because he trusted them. I also imagine this made the work more rewarding for the rest of the staff, since they felt they were in the driving seat.

There was one patient encounter during clinic that I will never forget. Jim (not his name) was a 15-yo black male with type 1 diabetes. His single mom was raising both him and his twin sister alone, both of whom were in the depths of adolescence. For several months, Jim had been finding a way to alter the blood glucose readings on his glucometer so that they appeared to be in range. However, his hemoglobin A1c (3-month average blood sugar) remained sky-high. The team had run all sorts of fancy tests to confirm that in spite of the normal finger pricks, his sugar was actually very high. All members of the team had worked with Jim for months to try and get him to admit that he was somehow altering the results. No luck. The problem persisted for almost 6 months. The worst part was that without accurate daily glucose values, it was impossible to adjust his insulin. The day I was in clinic they downloaded his glucometer data and the values, for the first time in months, were high (i.e. believable). The entire team cheered and high-fived each other in the work room. It was an incredible sight. It took some time to understand why everyone was celebrating this child's poorly controlled diabetes, but eventually realized that this was the first time he provided

honest results. In the exam room Dr. X asked, "So what happened?" He and his mother explained that over the summer he took part in a youth camp that promoted healthy living. This included regular exercise, healthy eating, and promoting natural whole foods that they grew in an urban garden. After completing the camp, Jim took a newfound interest in his health, and started following his blood sugars more closely and taking his insulin with every meal and snack.

As someone who wants to be a pediatric endocrinologist, this encounter taught me many things. For one, it taught me how challenging it can be to work with teenagers. There is very little a parent, let alone a physician, can do to control the day-to-day actions of a teenager. This presents many problems with a disease such as type 1 diabetes. Death, for example, could result from the strong-headed actions of a teenager. Fortunately, Jim's behaviors lead to chronically high blood sugar, which—while it can destroy your kidneys and retinas—will usually not kill you. Still, it is a helpless situation to watch a teenager set themself up to suffer greatly later in life.

I think the solution to these difficult patients is to be patient, consistent, and adaptable. For months, Dr. X stayed calm (at least in the exam room) and consistently counseled the patient and his mother. Further, other members of the care team (the social worker and psychologist) were working hard to try and understand what barriers in Jim's life were fueling his behavior. In the end, however, it was the heroes who ran the camp for underserved youth that are responsible changing Jim's world view.

This imparts a final important takeaway from my day in clinic: physicians are neither gods nor kings. We cannot order our patients to follow our commands—especially teenagers. Furthermore, we are not the source of every cure. In the case of Jim, someone completely outside of the healthcare setting provided his "cure." All we can do as physicians is our best, and seek help from our colleagues when we feel we have reached the limits of our capabilities. Sometimes help arrives from the most unexpected place.

COMMENTS: Great essay, --, what a wonderful conclusion: "Physicians are neither gods nor kings." I love that you chose a story in which, despite their patient, compassionate, and committed efforts, the physicians were not the heroes. They did nothing wrong, but they simply weren't the right people in the right place to reach this kid. As you point out, it was a group "outside", a camp of kids in a similar situation led by experts in adolescents with diabetes, who made the important breakthrough. Nevertheless, the team played an important role by "hanging in" with the patient, not shaming him, but rather persisting in trying to figure out solutions. When camp ended, the patient had a safe environment to return to, filled with people who'd demonstrated a sincere interest in his wellbeing.

This story is also a good reminder to be humble when we do have successes - it might not be because of our tremendous skills, but simply because we happen to be the right person in the right place at the right time. This is a wonderful thing, but I think it should be more of a sense of privilege than a sense of pride.

In terms of the endocrinology team itself, I'm glad you had the opportunity to see what a well-functioning team looks and feels like. Your observation that the clinic exuded a somewhat disorganized and frenetic atmosphere, yet somehow everyone finished up on time was so interesting - it suggested to me that the team was comfortable with a certain level of apparent chaos and had learned to make it work for them. This may have represented an accommodation to the patient population, and is a good reminder that health care systems are usually designed for the convenience of the doctors, not the patients. It's a helpful exercise to imagine healthcare systems from the perspective of patients and imagine transforming systems in ways that would consider patient needs and desires as well as those of physicians.

I also was fascinated by your remarks about how the endocrinologist often had other members of the team take the lead. I agree with your conclusion that he both trusted his team, and acknowledged

their expertise. When we talk about medical teams, too often we assume that the physician is always the head of the team. But that is not always the case. Even in the OR, sometimes the "lead" shifts from surgeon to anesthesiologist. In other teams, like the one you observed, or a geriatric team (which is similarly interdisciplinary), leadership may shift to the cognitive psychologist, or the nurse practitioner, or the social worker depending on the nature of the issue. A true leader, as you surmise, can recognize when to lead and when to step aside.

Altogether a very interesting essay that raised lots of thought-provoking issues.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

During my substance abuse elective, I was fortunate to have the opportunity to observe a psychiatrist interact with many different veterans that were enrolled in the Veteran Village Recovery Center program. I was also involved in the daily process groups, therapy sessions, and programming that was offered to all the patients. This allowed me to see how other providers such as social workers, yoga instructors and nurses interacted with the patients.

My observations in this clinic really highlighted to me the importance of diversity in medicine. The patients were very diverse ethnically and also ranged in age from early 20s to late 70s, and this same level of diversity was also seen in the staff members taking care of the patients. I felt that having staff members of different colors and ages allowed patients to feel more comfortable in the group setting and open up more about certain experiences. I also noted that each staff member had developed a different rapport with the patients as a whole. There were some that were seen as more strict and did not allow for side conversations or cursing to go on during group sessions and there were some that were more quiet observers and allowed the group to go off on more tangents.

From my observations, I also learned a lot about the psychosocial aspects of medicine and some of the soft skills required to be a better provider. I think the most important lesson I learned was about how passing judgement on patients can be a roadblock to providing better medical care. The commonality among all the staff members working in the clinic was that no one ever acted or said anything that could be perceived as judgmental towards any of the patients and I think this was crucial in helping them with their sobriety and recovery process. Another thing I noticed was that the medical team was very open to and often relied on suggestions and comments within the group to continue the discussion and help patients. It made me realize that oftentimes we see helping patients as just a solo, one-way road and we forget to elicit the support of their loved ones and family. It made me think about all the times I was seeing a patient in a clinic setting and became so fixated on the diagnosis and plan, but I never thought about eliciting the patient's perspective or asking about how the plan may affect their family life. Lastly, I recognized how invested a lot of the social workers were in the recovery of their patients. I think they were very successful in walking the fine line between

caring about their patients but also keeping a safe enough distance for their own sanity.

COMMENTS: --, many years ago, during my first year at UCI, I had the opportunity to participate in a week long substance abuse experience. It gave me great insights into both patients and familieso struggle with addiction, as well as into my own family dynamics. It was a profoundly eye-opening experience, so I'm glad that you were able to undergo this sort of training as well.

I couldn't agree with you more about the importance of diversity in medicine. As you know, we have serious limitations in terms of workforce diversity, especially in terms of historically underrepresented minorities, although we are (all too slowly) moving in a positive direction. Diversity allows us to understand what we are seeing and hearing from different perspectives, and this is essential in truly comprehending patients.

Your point about nonjudgmentalness is well-taken. Suspending judgment is something we talk about all the time, but in fact can be harder to implement in practice than in theory. Because we understand so little of others' circumstances and lives, a rush to judgment is almost always misplaced and alienates the very people we say we want to help.

Finally, I have great respect for the "horizontality" that you describe. Physicians go to school a long time, and so are expert in certain things. But patients have a great deal of expertise about their own lives. Often it is only by listening to their patients that physicians can find the way forward. I appreciated your disclosure about how easy it is to focus on diagnosis and treatment plan to the exclusion of how these will affect the patient's actual life. Such a valuable insight.

Your final comment about the social workers I think has implications for physicians as well. As a doctor, you too have to learn how to connect emotionally to patients while not becoming overwhelmed. It sounds as though the social workers in the program were excellent role models. Certainly the SWs I know at UCIMC have mastered the ability to remain open-hearted and caring, while simultaneously being able to shut the door on work at the end of the day. It's both/and.

Thank you for this very perceptive essay.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I observed the palliative care team and the heme-onc team holding a family meeting with a patient in the ICU. Unfortunately the meeting went terribly. The patient was at end of life and family was expecting to see their heme-onc doctor, but he could not make the meeting. The palliative attending (Dr. A) was trying to lead the meeting, but the family cut in to interrogate The heme-onc fellow(Dr. B) as to why the heme-onc attending could not be there. Dr. B was at the tail end of a 24-hour call and was clearly tired. Dr. B tried to explain that the attending was in clinic(which may have been a white lie).However the family knew the clinic schedule and accused Dr. B of lying, and Dr. B said "okay, whatever, he's not here" and began to get defensive. Then Dr. A continued the meeting and asked Dr. B to discuss the prognosis of the case and what options there were remaining for the cancer. Dr. B started to explain that that the send-out genetic tests of the cancer showed the options were limited, but before Dr. B could get to the point, Dr. A then cut Dr. B off, accusing Dr. B of getting too much into the weeds of the genetic tests. Dr. B then started growing teary and angry and explained that it was necessary to discuss these tests. Then the patient's family sided with Dr. B and said they would like to discuss the tests. Then after the tests were discussed and Dr. A took the lead again, Dr. B abruptly left the meeting.

Clearly there were many factors that led to the meeting going so poorly. While Dr. B was in a troublesome situation apologizing for the heme/onc attending and going into a high-stress meeting at the end of a long call, Dr. B basically gave up on maintaining rapport with the patient family by dismissing their concern that the attending was not present. At the same time, however, I felt that Dr. A was too quick to antagonize and patronize Dr. B by criticizing Dr. Bin front of the patient. My impression was that Dr. A saw that Dr. B and the patient family were on different sides, and felt the need to side with the patient family and throw Dr. B under the bus. The meeting could have gone way better if Dr. A tried to alleviate the antagonism rather than exacerbate it.

What I got out ofthat unfortunate observation was that the little bit of extra effort from the care teams to align themselves with their colleagues as well as the patient can prevent a lot of unnecessary pain. Frankly, while I always knew itis ideal to feel intrinsically motivated to go the extra mile to provide excellent interactions with patients and colleagues, I learned the ultimately practical lesson that making one or two shortcuts or mistakes in these interactions can lead to disasters that are orders of magnitude worse than the effort required to go the extra mile.

COMMENTS: Ouch, this sounds really painful for everyone, and especially for the family there to try to grasp the devastating situation of their loved one. Your analysis is spot-on. 1) Although you never want to throw a colleague or superior under the bus, you should not feel the need to lie for them. This is in effect siding with the attending at the expense of the family. You should certainly not dismiss their very appropriate concern that the heme-onc of their dying family member was not even present. 2) On the other hand, although you always want to support patient and family, you should avoid doing so by attacking or undermining colleagues. 3) A good way of avoiding these pitfalls is to consider the perspective of everyone involved (family, fellow, heme-onc) and having empathy for their predicaments. From such a broad understanding, it is more likely that you can navigate a win-win for all concerned. 4) All specialists and other healthcare professionals need to work out their differences BEFORE a family conference and agree on a unified approach - or at least agree on how to

present differences. Seeing doctors at odds with each other is distressing and confusing to patients/family, undermines confidence and sows mistrust.

--, your conclusion is so spot-on. We are all tempted to take shortcuts, and sometimes it is unavoidable. But often it is true that these "shortcuts" enmesh us in much worse situations that require time-consuming and emotionally draining reparative measures. It is hard to take the time to align priorities and approaches with others, but these things usually don't happen spontaneously, and such haste, especially in such emotionally fraught situations as EOL, can do real harm. Thank you for understanding this so clearly.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

While I have been on SICU there have been many encounters that have stuck out to me in the way patients are treated. One in particular though that was extremely poignant was with a patient who had been struck by a car while riding his bike and was found down with a GCS of 3. He arrived to the ED and on CT scan there was clear evidence of an impending uncal herniation. At the scene he had no family members or friends, and only his ID was retrieved(which the police had)so we didn't even know his name. Despite knowing nothing about the patient's history he still received the best care the trauma team could provide, and after arriving to the SICU we continued to treat the patient to the full extent of our abilities, including attempting to find the patient's family. Through social workers and law enforcement agencies we were able to track down the patient's family in Minnesota. I was witness for the initial phone call where my chief resident broke the mother's heart by telling her thar her son was critically ill, while still remaining empathetic and sensitive to the subject. Despite all of our interventions we knew that the severity of the patient's injuries were catastrophic, and that he likely would not survive. This did not change our dedication to his care and comfort however.

Once the family arrived they too became our patients and we all recognized that they needed as much helpas their son. On the next day we organized a family meeting with the parents to go over their son's imaging, and they opened the meeting by sharing their appreciation of the care for their son. Through their tears they shared that they felt like we had treated their son like one of our own, and that this meant the world to them since their son always showered everyone with only love. Throughout all of the encounters with his family I often felt intense sympathy and emotion, especially when imagining what my parents would feel if they were in the same situation. By the next day the family decided on hospice care, and we supported their decision to move forward with this. After three days in the hospital the patient peacefully passed away.

This experience has stuck with me because it showed how care for a patient comes in many forms, and that remaining compassionate for them and their family should continue, even when there is no hope for their recovery. This kind of medicine is what I plan to continue to do when I am a resident, and eventually an attending, and seeing the families reaction to the team confirms for me that I want to be better for my patients by always showing empathy.

COMMENTS: --, this is a beautiful story, and I'm grateful you shared it with me. Like you, I was especially moved by two aspects of the situation: 1) the patient was all alone, unidentified, without family or friends to support him 2) his medical situation was catastrophic, and the team knew he would die. Under these circumstances, it is easy for the team to withdraw emotionally, pulling back from a "hopeless" situation that will trigger their own feelings of helplessness and uselessness, especially when the patient has no advocate.

Instead, this team embraced the patient as if he were their family, providing meticulous, high-quality care so that the actual family felt he'd been treated "like one of our own." When the family arrived, as you sensitively realized, they became the patients as well, needing care and compassion to help them absorb emotionally and intellectually the devastating news of their beloved son's grave condition.

One thing I'm struck by is how, even in the worst possible circumstances, we can avoid adding to others' suffering and even do something to ameliorate their anguish, by expressing kindness and

compassion. In such terribly difficult circumstances, people long for this consolation, and it is not hard to offer if we only recognize our common humanity, as you so graciously did when you thought about how your own parents would feel in a similar situation. This was a heartbreaking event, but the team handled it with grace, and that made a real difference to the family.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

is anecdote took place during an afternoon rounding session of my surgery rotation where the whole team led by the surgeon visited our postoperative patients. We stopped by a room to check on a patient who just got a gastrointestinal surgery that very morning. With hands firmly placed behind his back, standing tall and proud and several feet away from the bed, the surgeon asked the patient to lift up his own gown to expose the recently operated stomach. While his hands remained tightly glued to his back, the surgeon continued: "Now use both of your hands to press on your stomach. Yes, just like that. Now press a little harder. Does it hurt? Ok. Not bad. I will see you tomorrow then." And just like that, the brief interaction between both of them ended, and we walked out of the room. As we proceeded to the next patient, I suddenly found myself completely dumbfounded. Did that really just happen? Did a physician really just ask his patient to perform his own physical exam? I did not know whether to be taken back by his atrocious physician-patient interaction or laugh at how ridiculous that was.

Now looking back, every time I remember the story, I chuckle. He was probably the best surgeon I have ever met with unparalleled surgical skills and the best postoperative outcomes. So, why not give him some slack and let him be a little arrogant?

COMMENTS: All I can say, --, is that, interpersonally, this is a great example of an anti-role model! I cannot imagine what would impel a physician to behave in such a distancing and mechanical manner. And to what end? It's hard to believe that even with verbal instruction from a great surgeon, the patient could perform an adequate self-exam. The surgeon's behavior simply conveys that he doesn't think it's worth his time to enter the room, examine, and talk to the patient.

For me, your essay raises the perennial question: So long as a doctor excels at their work, do they need to be compassionate or humane? One school of thinking is that the physician is primarily a technician; and if their technical skills are superb, then their interpersonal skills are optional. However, increasingly research challenges this view. We know that patients (including surgical patients) heal better (i.e., require less pain medication, are discharged earlier etc.) when they feel their physicians are empathetic.

My thought here is that the dichotomy is a false one. We should never fall into the habit of thinking this is a technically amazing doctor OR a kind compassionate one. It should be both, and that should not be too much to ask.

ART OF DOCTORING 2019-20

CLNICAL OBSERVATION

I was able to observe Dr. X, a UCI Neurologist who specializes in neuromuscular diseases, more specifically amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease. I had no idea what to expect that clinic morning, other than that there was no cure for ALS and that patients progressively lose function of their bodies over the course of months to years. I was able to follow the neuromuscular fellows into each room and observe their interactions with the patients and families before returning into the rooms with Dr. X. It is hard to clearly describe the interactions in detail but witnessing Dr. X communicate and care for her patients felt almost magical and comforting. She was understanding of her patients, supportive, serious, sincere, all at the same time. One could see that her patients felt nothing but respect and love for her as their provider.

I saw patients at various stages of ALS. Some had minimal deficits with mild noticeable weakness in the extremities, others were fully wheelchair bound with severely limited capabilities requiring full support from loved ones and caretakers around the clock. I could see the grief, frustration, and sadness in the eyes of some patients and the concern, anxiety, and fear in eyes of other patients and family members.

One patient with ALS struck me in particular, a man in his 50s accompanied by his wife. He was wheelchair bound with decreasing grip strength and worsening dysphagia since his last visit. Throughout the encounter, he would say verbal comments that were noticeably aggressive, almost rude, to his wife who stood beside him. She looked resigned and sad, but those emotions seemed to take a familiar shape along the existing lines and shadows worn on her face. Once we were outside the room, the fellows were discussing amongst themselves how it seemed like the husband was being verbally abusive towards the wife and were concerned how long that had been going on for. It was evident that he was suffering, as was she.

When Dr. X entered the room, she engaged him with the usual questions and then jumped into the recent changes and worsening progression. His hardened exterior slowly folded away and he began to express his sadness and frustration felt at his core. I do not know how Dr. X did it, but she seemed to be able to meet the patients where they were at, no matter how different of a place it was. She does not say anything unusual or unheard of when interacting with her patients but her words seem to pierce her patients in the most heartfelt and comforting way. If there was only one physician I could emulate in the future, it would most certainly be her.

COMMENTS: Dear --, I loved that you used the word "magical" to describe Dr. X's interactions with her patients. Medicine, rightly, is a science-based profession; but in my mind there is no question that there can be something magical in the sense of awesome and mysterious that occurs sometimes in doctor-patient interactions.

I also appreciated your close observation not only of Dr. X, but of the patients; and that you observed not only their physical symptoms, but their various emotional reactions to this very difficult disease. This awareness will bring "magic" to your clinical work as well.

One thing I noticed about your description of Dr. X is that she was not afraid to tackle hard issues head-on (as you show with the patient who was verbally aggressive toward his wife), but did so with compassion and without judgment.

It sounds like you could not have chosen a better role model on whom to pattern yourself. I have reached a similar conclusion that it is often not so much what the doctor says as the attitude and presence with which they say it

Clinical Observation
September 2019

We had a patient that was very nervous about her cancer diagnosis. Although it was early stage, and deemed by us to be “easily curable” with surgery, she was extremely nervous. The physician taking care of her seriously said “to us, this not a big deal. But of course, it matters since it is happening to you.” I thought this to be a very honest reflection and assessment of the situation. And, acknowledging the patients feelings helped the patient feel like she was being taken care of. I felt sadness for the patient and empathized with the fact that this was a scary experience for her. It was eye-opening for me to see that beyond saying “this must be tough for you,” it helped to acknowledge that this was in fact, a big deal. I think that often as physicians we are quick to think that medical conditions are normal because we see them every day. But, it is important to take a step back and realize that while the condition may be normal, it is very abnormal for the patient. Not only that, clinicians are in a setting (hospital, clinic) that they are very comfortable in. The simple act of being in a doctor’s office can be anxiety inducing let alone discussing a cancer diagnosis. It is important for us to state that this can be scary and that we are in the position to help the patient through it.

COMMENTS: --, I love this example for two reasons: 1) the physician recognizes the gap between patient's and doctor's perceptions 2) They explicitly acknowledge it to the patient.

I also find your comment perceptive that cancer, or some other serious medical condition, is always going to be a big deal to the patient, at least initially until they can begin to understand its manageability from the physician's perspective. Diabetes is the primary care physician's bread and butter - a diagnosis? No big deal. But to the patient it means a chronic disease with all sorts of lifestyle implications and potential scary complications.

Finally, your point about setting is great! Everything that happens in a hospital is normal to the physician and medical team; everything that happens in a hospital is ABNORMAL to the patient, and thus frightening, disorienting, and distressing.

An acutely observed and compassionate essay!

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

Setting: Primary care clinic, an experienced attending physician addresses and elderly patient and her visibly upset adult daughter.

We often have encounters in which thin layers of tension and hostility are present from the get-go. Our training teaches us to openly acknowledge the emotions in the room in a non-judgmental fashion so that they can be addressed directly. "I'm noticing that you seem upset, may I ask what is causing you to feel this way?"

However, practice is rarely quite so simple. As long as the visit is productive, it feels unjustifiable to risk derailing the conversation by dragging hostility out into the open. More often than not, the grievance will be volunteered without our inquiry.

"I can't believe the emergency department got another CAT scan even though my mom just the exact same scan last week. I know they only do that to make money and that's not right."

My preceptor took a non-confrontational approach by making some non-statements and providing the number for patient experience. How would I have responded to this allegation? The daughter's understanding and assessment of the situation was flawed on multiple levels- my instinct was to correct and educate.

"Who is in charge of making sure my mother's medications don't interact with each other? Her diabetes doctor said she shouldn't take her sugar pill while she's on antibiotics. We wouldn't have known this unless we happened to have an appointment with him. I thought the point of having a primary care was to prevent these sorts of things."

How would one even begin to answer her question? By explaining the format of modern healthcare and what the professional responsibilities of each doctor are? Throw someone under the bus for missing a drug interaction? Defend an unknown entity's decision to accept a moderate risk of drug interaction without informing the patient? What can we do when patients ask valid questions that they most likely will not understand the answer to? My preceptor began on a convoluted explanation of how common drug interactions are, how medical decision making is made, how certain specialists have more insight on the importance of certain medications, and how no single person is in charge of all drug interactions.

The daughter demonstrated her lack of understanding by asking her question again but in a more frustrated tone.

What did I learn?1) It is safe to avoid giving patients your opinion on care provided by other doctors (unless something sounds obviously wrong/dangerous)2) Solution focused language can help bring

closure (e.g. refer to patient experience)3) People behaving unpleasantly can turn pleasant after having an opportunity to share their grievances, whether or not you really address them.

COMMENTS: --, you extrapolated some useful lessons from this complex encounter. You make an excellent point that addressing emotions explicitly must be done with skill and a sense that you know where you're going. I also agree that not every emotion needs to be addressed - you can arrive at an exam room a bit late, and the patient is a bit miffed, but you proceed with a quick apology and the patient rebalances emotionally and all is well. The rule I follow is when the emotion is the "primary presenting symptom," it's wise not to ignore it. In other words, if the patient's frustration, anger (or joy!) is the most serious thing in the room, then it requires acknowledgment.

It's always good to think when you open that door, where are you trying to go? Reasonable goals might include: 1) giving the patient a chance to vent and feel seen and heard (ties in with your point #3) 2) providing resources to the patient (related to point #2) 3) providing clarifying information. #1 is always possible, and often sufficient. 2 and 3 depend on the specific nature of the patient or family member's concerns.

I agree entirely that one thing you should avoid is throwing other professionals under the bus. You are only hearing the patient/family member's side of the situation, and there may be extenuating factors. Too detailed content explanations may simply bewilder the patient and family further.

Sometimes it can help to listen for the question behind the question, the root issue that is bothering the patient and family. For example, in this case, it may be something like, can I trust you to take good care of my mother?/ Are you thinking about my mother's wellbeing?/ Do you care about my mother? These sorts of underlying fears can be addressed in a rather simple, straightforward manner without getting caught in a briarpatch of explanations about drug interactions, medical decisionmaking, different medical specialties and so forth.

I thought it interesting that, after the lengthy explanation provided by the attending, the daughter simply asked "her question again but in a more furstrated tone." This kind of repetition often means that the patient/family feels you did not understand their question, or responded in a way that was not meaningful to them. Again, to me this suggests that the patient was less interested in a disquisition about drugs and specialists and perhaps was looking for reassurance and commitment.

As you say, there is no simple way to handle these uncomfortable moments, but if you decide they require addressing, then listening for the underlying concern and responding with patience and empathy is a good starting point.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

During my rotation on OB Ultrasound, I learned a great deal about the art of counseling in difficult situations and patient autonomy. During one interaction, a patient presented with first trimester screening positive for Trisomy 18 as well as Smith-Lemli-Opitz Syndrome (SLOS). Although the screening test is merely suggestive, not diagnostic, it is still very concerning both to the patient and provider. The patient was an otherwise healthy twenty-something year old mother of two. She had never had any abnormal screening exams in her prior pregnancies. To completely rule out devastating fetal anomalies, the medical team offered to perform an amniocentesis, the diagnostic test of choice. Because the patient had never been offered an amniocentesis before (given her prior normal screening exams), she did not quite understand why it was offered in this circumstance. Additionally, she didn't understand why the screening exams, and even secondary blood tests, could not give her a definitive diagnosis. Without a medical background, she also did not grasp the gravity of Trisomy 18 and SLOS and what it would mean for her fetus.

I was very impressed by how tactfully and empathetically the physicians handled her counseling. They patiently explained the difference between a screening test and diagnostic test on a level that she could understand. They discussed very candidly the risks of amniocentesis, including miscarriage. They listened to the patient's concerns, answered all questions, but never pressured her into a decision to undergo amniocentesis or not. They presented all the medical information in an unbiased, compassionate manner and I could tell that the patient appreciated the time spent.

As I witnessed the interaction, I felt very comforted. I tried to put myself in the patient's shoes and imagine what I would do under the circumstance. On one hand, as a patient I think I would want the doctors to tell me the "right things to do" so that I wouldn't need to make the decision myself. But, on the other hand, I could tell that once the patient made a decision about whether to undergo amniocentesis, she was confident and felt supported by the medical team. I think she was much more empowered to have made that decision on her own. I learned how difficult it must be for a physician to remain unbiased even when he/she probably has an opinion about what he/she would do in the patient's situation. However, I hope to always have the ability to counsel in the artful and patient centered way that the high-risk obstetricians do.

COMMENTS: --, you do a great job in this essay of showing exactly why communication between doctor and patient can be a challenge. In a distressing situation such as you describe, there can be huge lack of understanding and misunderstanding. Add to that strong emotions of shock, fear, disbelief etc. and it's a recipe for confusion.

Also, I really appreciated your point that the team did not pressure the patient into a particular decision. Just because this stuff is initially hard to grasp should never affect the autonomy and decision-making of the patient. The key, as thankfully happened here, is that the medical personnel take the time and demonstrate the caring that will enable the patient to make a truly informed choice. Thank you also for noticing (and taking to heart) that this approach resulted in an empowering and confident outcome for the patient.

You are so right that it can be very hard to separate your own ideas about "what is right" from the patient's decision. In my experience, when you know that you've explained pros and cons to the best of your ability in a fair and thoughtful way, have ensured that the patient has a good understanding of

the risks and benefits, and have been able to incorporate the patient's values, then it is easier to let go, and trust the patient.

Art of Doctoring 2019-2020 Clinical Observation

I had the privilege of watching Dr. X interact with her pediatric patients in her clinic in Santa Ana. What stood out to me was how Dr. X listened to each of her patients. Physicians are generally very busy and have a lot of patients to see. Sometimes this stress is perceived by patients as their doctor trying to rush them in and out the door. Even though this might not be their physician's intent, patients may feel as though their doctor is not interested in in the patient as a person. Dr. X, however, gave each of her patients the time to speak and express concern no matter how far behind she was in clinic. She also truly cares about the well-being about her patients even if that means telling them to not come back to clinic for a while.

One patient encounter that really stands out of my memory was when Dr. X was speaking to a teenage girl in her FIT clinic. This specific clinic is for children who are obese to help them try to make healthier life decisions. This specific teenage girl also had autism, was struggling with her gender identity, and was constantly arguing with her parents. When we talked into the room, she was saying profanity to her mother. We sat down with her and Dr. X started to discuss her eating habits and she was so agitated she became verbally aggressive towards us. Dr. X listened to her complaints until she began to cuss at us. Dr. X very calmly said "I know you are upset but we do not use that type of language here". She stopped cussing and calmed down a bit. Dr. X after hearing the girl's problems decided it would be best if she took a break from coming to clinic because the conversations about her weight were not working. The mother and the daughter agreed, and the encounter concluded.Dr. XX afterwards asked how I was doing, and she expressed how she did not know how to handle the situation. This patient was extremely complicated with a complicated social

history. She thought the best way to approach the girl was to just listen to her complaints. However, she needed to be an authority figure when the girl was becoming aggressive to set appropriate boundaries. Ultimately, she thought that the conversations about her weight and making healthier eating habits was causing her anxiety on top of the multiple other issues she was facing. She thought that taking the rest of the year off to see therapists and other physicians would be a better use of her time. They would then resume their appointments in the new year. This was a difficult encounter for everyone, but Dr. X's ability to listen, but also set strong boundaries was impressive.

COMMENTS: --, I am fortunate to know Dr. X, and I agree you made an excellent choice of role model. You did a great job of noticing WHY she is such an effective and compassionate physician: listening attentively and being truly concerned about each and every patient.

There are several interesting points about this particular interaction. One was how Dr. X handled the patient's profanity - not escalating, staying calm, but setting a clear limit. This is a good reminder that being a compassionate physician does not mean tolerating disrespectful or aggressive behavior.

Secondly, I appreciated her concern for you, her medical student. It is never pleasant to be verbally assaulted by someone, even if you understand the reasons why, and Dr. X's sensitivity to how this interaction might have affected you is really admirable.

As well, I admire the fact that she asked your opinion. This was indeed a difficult and complex situation, without easy solution. She handled it in an interesting and skillful way, but was also eager to hear your thoughts - which might have shed additional light.

Finally, to me this is a fascinating example of a physician willing to put the patient's interest above her own needs and beliefs. I know that Dr. X is deeply committed to managing childhood obesity and to the FIT clinic. No one likes to admit that their passion is not working. However, in this instance, she concluded that the additional stress of FIT clinic was complicating the coping of an already struggling patient, and that the wisest course of action was to back off. What an excellent lesson in humility, and in knowing when the time is right - and when it isn't!

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

The last week I have been in allergy and immunology clinic with an older physician who has been fascinating to work with because of his experience and knowledge. He says he has been working at this clinic for 38 years and is also a physician scientist who has published over 500 journal articles and written 37 textbooks. Observing his physical exam with patients is interesting because he is incredibly precise and repeats every step, every time. He will feel the patient's pulse for about one minute as he makes small talk and, in fact, has been the only physician I've observed to percuss the lungs.

Last week we had a patient who presented with a lengthy medical history and prior diagnosis of chronic fatigue syndrome and fibromyalgia. This physician thoroughly chart checks before each visit and already has a sound knowledge of the clinical picture. He remarks the diagnosis of chronic fatigue is ominous because it is a diagnosis of exclusion meaning there is no other medical explanation for his symptoms. The nursing staff also remarks that the patient has a strong personality, which is evident when entering the room. Upon meeting, the patient launches into a detailed medical history starting from thirty years ago when he had high fevers and his chronic battle with mysterious illnesses culminating in multiple chemical sensitivity syndrome, unknown autoimmune disease and multiple allergies to trees, dust, air, pollen, mold. It truly is overwhelming, and from a medical standpoint, rather meaningless.

My attending counters by asking who diagnosed him with allergies. "No one," the patient replies "I just get sick."

"Well someone must have diagnosed you, this is a medical diagnosis. Who was your previous allergist?"

A lengthy argument ensues over when exactly and who exactly the patient has seen. The room felt very tense and stressful as the attending carefully countered the patient's claims. He eventually directed him towards seeing a neurologist for his peripheral neuropathy for a potentially true diagnosis that would lend insurance coverage for IVIG, which on some off chance may alleviate his symptoms. Though it would not be my personal style to engage in an argument with such a patient, I was impressed by my attending's careful attention to detail and willingness to even engage in this conversation.

By the end of the visit the patient and the wife were both smiling and outwardly happy to have their questions answered and concerns acknowledged. Again, the patient launches into a lengthy explanation of a book he has written titled "Poisoned", sold on Amazon and asks us all to please read it to understand how environmental chemicals are a leading cause of death and disability. My attending says, "I have another patient, thank you I must go," though I know it is 11:50 and we are seeing the last patient of the day.

This was a good learning experience because I was impressed that my attending was able to meet this patient's needs despite the very difficult, medically nebulous and almost confrontational encounter. It was inspiring to see him listen with patience, though also maintain firm professional boundaries. Even though he is an expert in the field, he did not lead with his ego and was able to come up with a solution that may give the patient some closure in upcoming visits.

COMMENTS: --, I too found this to be a very interesting dynamic. My favorite line in your reflection was "he did not lead with his ego." The higher you rise on the medical hierarchy, the more experienced and expert you become, the easier it is for your ego to engage in all sorts of interactions - with patients and families for sure, but also with colleagues, consultants, even your spouse and children. This physician was obviously quite distinguished, yet as both you and -- note, was able to strike the right balance between interest and firmness. It seemed he was genuinely concerned to help this patient find answers, but also knew when to end an encounter that was veering offtrack.

The argument about diagnosis was quite interesting. Often, I agree with you, --, that arguing with a patient can be a pointless exercise. Proving the patient wrong may be satisfying to some physicians, but often destroys trust and leaves the patient feeling blamed and inadequate. However, an argument motivated not by ego, as you say, but by a genuine desire to help the patient see his situation more cleary, may be important. Although you observed that the "room felt very tense and stressful," it seemed that the attending remained calm and curious, genuinely pursuing understanding of what was going on with the patient. I would interpret this as being able to stay centered in the patient's upsetness and focused on getting to the bottom of the patient's symptoms.

In such situations, it's always valuable to ask yourself, am I engaging with this issue because this patient annoys me and I want to put him in his place? Or do I think it's important for helping him understand his situation better and find a better approach to dealing with his symptoms? Reflecting on this question can help guide how you proceed.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

As a student rotating through radiation oncology clinic, I was submerged in an entirely new environment. This patient population is all of the people in our community battling diseases which should never have existed in the first place. Literally young otherwise healthy adults who have now been branded with the diagnosis of CANCER. I feel as though this subset of patients are among the strongest in the entire health system. After working with each of the attendings, I have found that there is no displacement for actual physical face to face time spent in the clinic to truly understand the patient. This was a nice change when compared to other clinics where the attending only spends <5 minutes with each patient. In this clinic, the attendings spend an entire hour with the patients which I believe makes a notable difference in terms of the patient's trust for their care providers. The patients are told that they have this fatal disease process, and the treatment is basically highly toxic radiation and highly toxic chemotherapy. I found that by being very clear and empathetic these providers are able to empower the patients with hope, courage, and strength. I will always try my best to spend as much face time with patients as possible during my practice. I will continue to show empathy and to put my patients above all other matters.

COMMENTS: Dear --, I'm so glad you had this experience on rad onc, and that you were able to get so much out of it. You saw that by taking time and building trust with the patient, the physician can help them face devastating diagnoses and horrifying treatments. Illness, especially a serious illness such as cancer, can be very isolating to the patient. The patient wants someone, if not to walk in their shoes, at least to walk beside them, to be their guide and companion. That does take time - but it also requires a certain attitude or state of being. The radiation oncologists I've known give their patients courage because they themselves have learned to look into the face of death without flinching, with honesty and compassion. This capacity gives their patients hope and strength.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

OBGYN was my first third year rotation. It ended up being one of my favorite rotations, not because of the subject matter but because of some of the physicians I worked with. I specifically remember one gyn-onc fellow, --, who was so bright and happy all the time. She lit up every room she walked into and put a smile on every patient's face. I thought that this was especially important, given that many of her patients were facing terminal diagnoses.

One day, -- entered the room of a patient with metastatic ovarian cancer. You see the patient's eyes, red from crying, get large as if we were there to deliver a significant update. Unfortunately, nothing had changed; her prognosis was still poor. As the residents and I turned to walk outside the room, -- squatted down and talks with this patient eye-to-eye while holding her hand. She didn't promise that everything would be ok; she didn't say that there was "always a chance." She just sat there and told the patient: I'm here for you. I'm sure the patient had heard this a thousand times before, but the genuine compassion -- exuded, combined with her being eye-to-eye with the patient, created a therapeutic effect unlike anything I'd ever seen before. The patient stopped crying and simply gave her a slide nod. Things seemed ok.

A few days later, before scrubbing into the OR, -- asked me what specialty I wanted to go into. I told her I was unsure, as this was my first rotation, and asked, "What would you expect of me if I decided I wanted to go into OBGYN?" She looked at me and said without hesitation, "We want our students to care about our patients as much as we do." It sounds cheesy and cliché, but looking back at that moment with our patient with metastatic ovarian cancer, I could tell that she was being honest. Her main concern was the life of her patients.

Whether it be --'s interactions with the patient or with me, I look up to her as a role model in so many different ways. I had never thought about squatting down to my patient's level but after having been a patient in the hospital myself a few months ago, I started to realize how important and powerful that can be. It's nerve-wracking to have a group of physicians come in and tell you what is going to happen.

Moreover, there are so many ways that you are of the inequity in your doctor-patient relationship throughout your hospital stay. Whether it be a standing group of doctors surrounding a sprawled-out patient or the standardized uniforms medical professionals wear juxtaposing a flimsy patient gown, there's a constant reminder that we are not equal in this "partnership". --'s ability to recognize this, especially in a patient's darkest moment, made a significant difference in this patient's hospital experience. It may not have changed her clinical picture, but it at the very minimum gave her solace in the fact she had a physician who cared about her more than anything else. That's the type of physician I aspire to be; I just hope I don't become too jaded before I am able to reach that goal.

COMMENTS: --, I loved that you noticed the "squatting." While it doesn't always "fit" in a given situation, it is such a humble, intimate posture, and I'm always moved when i see doctors adopt it. I also appreciated your awareness that providing false comfort or reassurance under these circumstances would have been very misguided. Of course, the patient wants hope, but there are different kinds of hope; and a very important hope is the trust that your doctor will not abandon you when "there is nothing more that can be done" (terrible phrase btw).

I hope that your interaction with -- showed that caring about patients leads not to burn-out but to satisfaction. I can see that it heightened your awareness of the importance of always remembering the patient perspective, and how traumatic a serious diagnosis can be.

Your appreciation of the power imbalance in medicine is really important. Patients, by definition, are at a disadvantage; and this helps us to understand that sometimes, when they act out, they are trying to reclaim some power and control over their own lives. This doesn't excuse bad behavior, but I think it can make us more sympathetic. On the physician side, especially in moments of such distress for the patient, anything you can do to reduce the distance between you and the patient is valuable. When the patient needs your comfort and consolation, they want the human you, not the medical expert you.

Finally, you are so right that, while changing the clinical outcome is what all patients want, even when this is impossible you can significantly alter their experience by how you behave, giving them hope that they will not be alone and that they will be well cared-for. In such difficult moments, this is a great gift.

So bottom line, do not allow yourself to become jaded :-). This will hurt both you and your patients. When you feel that cynicism, disillusionment, and resentment creeping in (as they inevitably will), remember --.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

When I was on my Ob/Gyn rotation a patient came in with a molar pregnancy. She had been bleeding for a while and had gotten a quantitative B-HCG at an outside hospital which was 180,000, well above the threshold for a normal pregnancy. She was told to come to the emergency department at UCI where she arrived with her husband. Up until this point all the patient knew was that she was about 8 weeks pregnant, and that something was not right.

I came in with our senior resident who performed her exam and an ultrasound and confirmed the findings. She then explained, in a clear and concise manner, the situation. This pregnancy was not viable, the patient needed an urgent D&C, and she would need to be monitored for the next six months because of the risk of a very aggressive cancer. Any one of these items singly would be overwhelming for a patient, but all of them together are absolutely daunting. The resident did such an amazing job answering things at the appropriate level of detail, providing consistent answers for the patient, and constantly exuding empathy, explaining to her exactly how we were going to take care of her.We were able to get an OR spot for the patient within the hour, and shortly thereafter we performed the vacuum aspiration without complication.

When the patient was in the PACU we went out to the waiting room, where the patient's husband was waiting, to tell him that everything had gone smoothly and we expected her to wake up shortly. He was beyond grateful and thanked us profusely. His gratitude was almost surprising to me. He had had one of the worst days of his life, and we, after all, were just doing our job. Yet the residents kindness and empathy made him feel safe in a terrifying situation.

Working with this resident, and this situation especially, made an impression on me. I realized I wanted to attain the level of competence and confidence that she had to know exactly what to tell the patient in terms of what to expect, and to perform the procedure successfully, and also the bedside manner to do so while meeting them at their level and being a calming presence.

COMMENTS: --, what struck me about your essay was that marvelous combination of competence and caring that this resident displayed. She had obvious command of the medical knowledge necessary to explain a baffling and complex situation. She also had the compassion to support and care about his patient at every step.

I loved your observation that "any one of these items singly would be overwhelming for a patient but all of them together was absolutely daunting." How empathic of you to realize that this patient and husband were going through a devastating series of shocks - nonviable fetus, facing an immediate D&C, the possibility of aggressive cancer. Your awareness that this was not simply about transmitting information and consent, but about helping a patient deal with a world turned upsidedown shows your significant emotional intelligence. I was equally impressed by your recognition that the way the resident handled the situation made the husband feel "safe." This is a really important achievement - hospitals are terrifying places for patients and family members. Making them feel that they are in good hands, hands that care about what happens to them, is an essential part of good care.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I had the privilege of sitting in on a family meeting on the inpatient side of the hospital and observing the interactions between the medical team (the intern resident, senior resident, and RN), the patient, the patient's family, and the interpreter. The patient was an elderly female with multiple medical problems and who had been bed-bound after a prior stroke several years ago.

After many weeks of admission for difficulty breathing, the team was discussing the patient's new diagnosis of metastatic cancer, the prognosis, and the treatment plan moving forward. As goals of care discussion can be very difficult and sad, I saw that the team took care to ensure the setting was as comfortable as possible. The patient was moved from a shared room to a large private room, and multiple chairs were moved in so that everyone could sit in a circle with the patient included on her bed. The team waited for everyone to be present and everyone present introduced themselves.

The resident started off with a brief and concise summary of the patient's hospital stay thus far, and I saw how this helped make the family comfortable byre-confirming their knowledge. The resident then moved on to laying out in broad terms the options for progressing forward. Importantly, I saw that the team did not offer their opinions on what the patient should do -- they gave them the time to digest this new information and to ask questions. This helped to give the patient and family as much control as possible over the future.

This careful, initially objective approach also strengthened the patient's trust in the medical team, as she then proceeded to ask the team for their personal opinion on what to do. The interaction was a good reminder of how important trust is in the physician-patient relationship, and that being aware of little details, such as the setting of the room, were just as important as the medical discussions.

Another important aspect of the interactions was the way that the interpreter was involved. could not speak English, although her family could. From the beginning, I saw that the medical team always addressed the patient directly and made eye contact when speaking, and then waited for the interpreter to translate. I could see that this made the patient feel more directly involved, whereas if the team had relayed their messages to the interpreter, the patient may have felt shut out of the discussion. In addition, when the family began to ask many detailed questions in English, the team would make sure to pause and give time for the interpreter to translate these discussions for the patient. Once again, by making sure that the patient was involved in every aspect of his care, I saw that she was much more comfortable medical team, her knowledge of the disease, and the decisions she made.

COMMENTS: Dear --, from your description, this sounds like an ideal family conference. As you say, these discussions are usually difficult and sad, as well as bewildering, and despite good intentions do not always go well. Sometimes, as I'm sure you've seen, families leave more confused than when they came in. By contrast, although this situation too was very sad, everything was done to make patient and family feel included and allow them to maintain a certain level of control.

What impressed me was how carefully you identified the factors that made this an effective and compassionate discussion. You are so right that attention to small things, such as a private setting and having enough chairs really makes a difference. I also appreciated your observations about how the

resident first summarized, then gave patient and family time to process, and finally responded to their questions, which included soliciting their advice. You also noticed how skillfully the team made use of the interpreter, and how through this approach, it was possible to keep a non-English speaking patient engaged and involved in a discussion about her life.

Finally, you showed great sensitivity to the emotional climate in the room. You realized that this encounter involved the transmission of information, but also perhaps coming to terms with mortality and beginning the process of contemplating the final phase of this patient's life. Of course, that is always a challenging conversation, but with thoughtfulness, patience, and creating space for the patient and family to guide the discussion, it can be handled in a caring and helpful way, as was the case here.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

While on my ICU rotation at the Long Beach VA, I witnessed two very different styles of difficult conversations. However, they were both with the same patient, in the same room, at the same time. I felt as though one clinician was trying to be as direct as possible, while the other was trying to be sensitive to the patient's wishes. It almost felt like a "good cop, bad cop" scenario, but that was definitely not the goal. The goal was actually to determine the patient's goals of care and discuss his code status. The first clinician came in, switched the CPAP to high flow nasal cannula so the patient could hear better, and sat down. He said, "Look, I'm going to be straight with you. You have end stage cancer and a shitty heart. On top of all that, your kidneys are failing now. There's not much more we can do for you." I was shocked at his brash word choice and thought the patient and his family would be too. To my surprise the patient said, "thank you for being honest with me. I don't think doctors understand that I know these things. I just need a few more days to get my will sorted out." They continued to discuss palliative interventions such as hemodialysis, CPAP, chemotherapy and if they'd be helpful in keeping him comfortable while finalizing his paperwork.

During this interaction, the other clinician arrived to join in the discussion. This clinician was much gentler in their approach. They brought up the patient's full code status, meaning that they would undergo life sustaining measures such as CPR and intubation. She said, "Not that I am expecting anything to happen in the next few days, but we always want to be prepared for an emergency, would you want us to do everything we can to keep you alive?" Initially, the patient and his wife seemed to still want this. Then she said, "while we can keep your body alive with all the machines and technology available, it may mean that you are not awake enough to interact with your family or make any decisions regarding your advanced directive." The patient looked at his wife. I could see in their eyes that this was not something they previously understood. Then the other clinician chimed back in to say, "if we crack your ribs and put a tube down your throat, you probably won't be able to recover from that, so it'll be futile." After a little more back and forth like this with the two doctors and the patient, the patient ultimately decided to change his code status to DNR/DNI.

I feel that this patient interaction gave me an interesting perspective. One style is not superior to the other. The approach should be individualized to the patient. They need to be met where they are. The first clinician may not have been very sensitive, but I think he could sense the patient's frustration and knew he was a Marine who could handle harsh words and situations. The second clinician was not as direct but helped to make the patient and his spouse feel comforted and supported in their decision to no longer desire resuscitation. I hope to gain the experience to know when it is appropriate to use each of these tactics.

COMMENTS: --, I would kind of like to roll these two approaches into one person! The research I've seen suggests patients want doctors to bring up end of life/goals of care discussion, but to do so in a way that demonstrates caring and kindness. (Btw, a "tough" approach can also be a kindly one. Your mentioning that the patient was a Marine was quite perceptive - he may have preferred a less touchy-feely, just-the-facts interaction. However, even with this style, it's important that the physician convey that they care about the patient).

The danger of a gentler approach is that it results in a lot of fuzziness, which patients understandably want to latch on to. So to me, it seems to be important to be crystal-clear and crystal-kind.

I'm also reminded that the way we say things is so important. When you phrase CPR as "Would you want us to do everything we can to keep you alive?" it's pretty impossible for the patient, and especially the family, to answer no. So this was "leading" the patient toward a full-code response. But when you say, "Look, a code is a brutal process, and you probably won't be able to communicate afterwards, make decisions, or have any kind of meaningful recovery," it shifts the conversation toward a no-code status. I think balancing such discussions so that the patient is not "pushed" in any particular direction while really understanding what is being decided is ideal, although still very subjective and hard to achieve.

I'm glad you're paying such careful attention to a seemingly superficial attribute such as style. As you saw in the way this interview played out, the physician's approach can have a profound influence on the patient's and family's level of trust and ultimate decisions.

January 2020 Art of Doctoring Clinical Observation

I am currently on my Medical ICU rotation at the Long Beach Veteran's Administration Hospital. Though there certainly may be an element of a recency bias given the fact that I am still working with her, my fellow at LBVA is the first person that came to mind when reading this prompt. She is one of the most compassionate, genuine, and knowledgeable physicians I've worked with thus far. We have had numerous deaths over the course of my time there, a few of whom were patients I was taking care of.

One family in particular was a gentleman, his wife, and his young college-aged daughter. The father was intubated in the MICU, with an extensive cancer burden and an overall poor prognosis. As different teams came to speak to the family each day, they grew more and more confused about what his prognosis would be and what quality of life he would live at this point. Moreover, the mother continually turned to the daughter to help her make some major decisions about her father's care. The stress of deciding matters was clearly eating away at the young girl. She put on a tough face. She was pre-pharmacy in college and asked questions about her father's medications and labs to avoid being emotional. But she looked in pain every time I saw her talk about her father's prognosis and decisions about his end of life care.

One afternoon, we were able to sit down with the wife, the daughter, the Palliative Care service, and the MICU team. Over the course of that discussion, the wife verbalized that she felt her husband would want to be on comfort care at this point. The daughter broke immediately – she had been trying to convince her mom that her father would not want to be intubated or fighting anymore and, as she later expressed, she really did not believe her mother would agree. I found myself fighting back tears watching her simultaneous relief and agony. It seemed to me to be an impossible situation – the mother and the daughter needed different things from our team in terms of their grief, and yet we were all in that room together.

The fellow validated the painful decision they had both made, the thing that unified the two, and stated that the decision to transition him to comfort care was not an act of them giving up on their loved one, but rather showing up for him in a way that was the most painful, the most heartbreaking, the most challenging, and the strongest decision they could make. Then she told the daughter how strong she was and how her father would be proud. She walked across the circle of people sitting and hugged her. I watched the girl collapse into tears in her arms. She'd had weeks, and more likely months, of being the strong one for her mom and her dad. Months of making decisions far beyond the scope of a 21 year old. In that moment, she was a kid whose dad was about to die.

My fellow taught me that it's okay to feel with your patients, to be devastated and sad with them, to hug them when it seems appropriate, and to sit with them in their grief. She also taught me how important the moments surrounding death are, demonstrating how crucial it is to take the opportunities to resolve conflict, to validate decisions, and to sit with your patients and take the time to show that as the physician you care deeply for your patients.

Finally, at the end of the day, and after every difficult patient encounter I've had in the MICU, she texts and offers support, recognizing that although she deals with critical care and death in her day-to-day life, the intensity of emotions and the exposure to death may be something more than we've experienced as students thus far in our training. This family interaction will stay with me forever, and

the lessons I learned from the entire team, but mostly from my fellow, will make me a more compassionate, genuine, and comprehensive provider.

COMMENTS: --, I'm so impressed with this fellow; and also so impressed with you that you saw and understood so much about why this fellow's interactions were so skillful.

You made several extremely perceptive observations. One was to acknowledge that mom and daughter were initially in different places, and that they almost had a kind of role reversal in their relationship - that the daughter was in a way caring and supporting the mom. You also saw how the fellow was able to help them see their common ground; and to engage in the important task of reframing their decision - moving to comfort care was not "giving up" but following their loved one's wishes and actually an act of strength and courage. Finally, you realized the significance of the fellow hugging and thus literally supporting this young woman who, because of the family dynamics, had been forced to shoulder a heavy burden of responsibility. In that hug, the fellow gave her permission to be simply a kid again whose father was dying.

The lesson you extracted is a wonderful one - you saw firsthand that allowing yourself to feel something about your patients is not a weakness nor something that will harm you - indeed, it is a way to remind yourself daily of your humanity. You may discover as well that, when you acknowledge your own feelings while placing them in the service of your patient, although they may cause you some distress you will, more often than not, see them not as a burden but as a privilege, a way of witnessing and supporting the suffering of your patients in a way that gives both of you strength.

Finally, my admiration for your fellow only grew when I learned that not only did she treat her patients and their families in such a loving, caring manner, but she also took time to be concerned for the wellbeing of her less-experienced students. For me, this shows a physician who is the consummate clinician and teacher, who cares for the whole person of patients and students. This is indeed someone to emulate.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

My interaction that I was particularly impressed with was with my Senior resident while on my Medicine Sub I and his interaction with his patients and other staff. With staff, consults, and other teams he would readily agree to help when we were able which often meant taking on extra patients, much to the improvement of the interns. He would argue that when we need help the other teams would aid us just like we had helped them during their time of need. I loved this mentality which was a true team attitude for not only Team H but for the whole hospital itself.

In addition to the, my senior also had a remarkable interaction with his patients. He had a genuine sense of care for their concerns even though to many other providers would have simply been written off. One example of this was with a patient who was younger and placed on a 5150. He took the time to comfort her because she was scared and explained everything that we would be doing to help her in addition to what to expect while at the hospital. I have been in this situation with many other teams but the way he orchestrated himself left the patient comfortable despite her situation. I hope to continue to practice in a way similar to how my senior conducted himself as I progress through my training.

COMMENTS: --, I like that you highlight not only this resident's excellent communication skills with patients, but also his commitment to true teamwork. I have seen more than my fair share of physicians who treat their patients commendably, but are rude or demanding toward medical students and staff. Teamwork is the essence of good medicine, and it is the wise physician who can recognize this. I also appreciated your point that this resident had an attitude of helpfulness not only to his particular team but to other teams in general.

Your example of how the resident took time to comfort a young patient placed on a 5150 is memorable precisely for its simple humanity. There is no grand gesture here, just the recognition that the patient is frightened and bewildered; that he has the ability to lessen her distress; and that he made the effort to do so. These are the essential components of compassion-in-action: 1) recognizing another's suffering 2) recognizing that you have the knowledge and skill to alleviate that suffering 3) taking the necessary action. A lot of times someone can have one or another element of the triad, but having all three can make the difference between a merely competent and a truly outstanding physician.

I can see from your insightful observations of this resident that you have already set yourself on this path.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

During my internal medicine rotation, I had the privilege of getting to know and taking care of a patient near the end of her life. She had breast cancer that was refractory to treatment. She was started on palliative chemotherapy. I do not believe the family was aware or accepted that she was suffering and nearing the end of her life at the time. Initially, she came to the hospital for a rash that developed. When I came down to the emergency department to see her, I talked to her husband to learn about her story. When it came to asking her questions, the first sentence she said to me was, “I don’t want to see you, you’re just a medical student.” She refused vital signs, medications, and an IV bag. I understood that she was in excruciating physical pain and was exhausted about the medical system. Having a medical student see her was not going to change her prognosis. Although our team was going to discharge her, she ended up having complications from her chemotherapy, causing her to stay in the hospital for a couple of weeks. I had the opportunity to observe and work with different physicians and their approach to this patient’s care. The first physician was respectful, direct, and focused on acute medical problems like the rash, which was reasonable and efficient. When I brought up that she was claustrophobic and anxious about being in closed spaces like the bathroom, the concern was not addressed at the time as she had acute medical problems at the time. At the time, the patient was gradually more trusting of the medical team and started to agree to have some treatment. I felt that the patient was well taken care of, but her medical team had not yet touched base with her family about her prognosis. She was not eating because of her esophagitis from chemotherapy. In the afternoons, when I would check up on her, I saw how her nurses were so patient and encouraging to eat. They would celebrate her small victories even if it were small sips of juice. They would also continue to communicate with me about their concerns throughout the day. The second physician came in at a time when she was healing from acute illnesses and focused on her palliative care. He had the opportunity and time to ask the patient about how she was feeling and if there was anything he could to make her feel more comfortable. The physician was able to time to ask the family about their expectations when the family goes home and what their needs are.My interactions with my patient and seeing the various approaches helped me understand how to respect boundaries and meet patients and their families where they are in their journey. I will always be mindful of my observations with the team in taking care of the patient and experiences with my patient in becoming a better doctor. I learned sympathy and empathy in trying to understand and respect my patient’s pain, boundaries, decisions. I learned how different types of physician practice compassion. I learned that I want to become a physician that is competent and efficient, as well as compassionate and encouraging.

COMMENTS: ank you for sharing these two different approaches to a terminally ill patient. In my fantasy, they could be colapsed into a single physician, but I think what you're saying is that different circumstances may require different approaches. When the focus is on acute problems, the larger picture will be lost. Sometimes that's okay in the short-term, but in my experience, often the larger picture is never addressed either with the patient or with the family. The problem, in my view, is that exclusive focus on acuity may ignore what's really important. Maybe the patient was more concerned about being enclosed in the bathroom than about her rash. Maybe what really mattered to her was that someone would help her family grasp that she was dying. Since these problems are less easily "fixable" than rash, they may be neglected despite their importance to the patient.

In medicine, not unlike your patient, you too are always setting priorities, establishing boundaries, and making decisions. You cannot be all things to all patients. But by taking a patient-centered approach, as the palliative medicine specialist apparently did, you are in a better position to be guided in these priorities, boundaries, and decisions by the patient's desires and wishes. This is important at any time for any patient, but especially at end of life.

I also liked your observations about the nursing staff. This was a patient in great pain, exhausted by her illness, and struggling with preparing for end of life. She was dismissive of the medical student and often refused treatment. So not the easiest patient to care for Yet the nurses persisted with kindness and encouragement, and never failed to keep you in the loop about developments. For me, one of the important lessons is simply to stay the course with patients. They do not always respond positively, in the ways you hope for; but often simply "staying the course" results in greater trust and eventual cooperation, as occurred in this case.

--, I like your conclusion very much. I agree that the goal is to combine both competence and efficiency with compassion and encouragement. At any given moment in interacting with your patient, you may be leaning in one or the other direction, depending on the circumstances. But so long as you have both skill sets, you will be more likely to give what your patient really needs.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

-- was a 66 year old female with a history of diabetes and hypertension who presented to the emergency department for right upper quadrant pain, nausea and weight loss. She was admitted to the medicine inpatient floor and soon after became my patient. I learned a tremendous amount from --. The daily interactions between the medicine team I was a part of and --'s family highlighted an inherent discordance between the medical and non-medical world, which ultimately motivated me to be the type of physician that works to bridge this gap.During morning rounds, -- was referred to as "stomach lady" which transitioned to "cholangio lady" when further workup revealed that she had advanced cholangiocarcinoma. I watched as residents, in an effort to be efficient, dismissed my efforts to use a Spanish translator in favor of their broken and incomprehensible Spanish. When breaking the news of her cancer diagnosis, I listened as an attending physician counseled the patient from the doorway. Using his broken English, the attending threw advanced medical terms like "cholangiocarcinoma" to a bewildered and visibly horrified -- (who I would later learn understood very little from that initial discussion). These interactions between physician and patient were more than disappointing. In the hustle of handling a growing volume of patients, I watched as attending and resident physicians lost their compassion for patients and took advantage of the physician-patient power imbalance.

With this in mind, I hope to be a physician who approaches patients from a "whole person" perspective, who identifies them by their name, who provides the type of care I would want any family member of mine to receive, who takes the time to use translators knowing this may be the scariest moment for my patient and the burden of a translator may put this patient at ease. In the process of getting to know -- and her loved ones, I learned that she recently immigrated from a small city outside of Mexico City. Her true passion was cooking and her favorite activity was cooking a hearty meal for her family. She suffered from mild anxiety but she did not like to refer to it as "anxiety." I want to be a physician who goes the extra mile to uncover my patients' narratives.

COMMENTS: --, I can clearly see from the small details you provided about --'s life how much you knew about her and how much you cared about her. All I can do is encourage you not to despair, rather continue to fight the good fight. Compassion often does disappear as the pressures of training and practice increase, but this is not necessarily the case. Ironically, it is by maintaining connections to patients that physicians most often find inspiration and the courage to continue in their work with commitment and sometimes even joy.

The particular short-cut you mention (refusing to use an interpreter and instead employing "broken and incomprehensible Spanish") is a symptom of not-caring - not caring about getting communication right, not caring about the patient's feelings, not caring whether the patient understands; perhaps only caring about getting through with one patient and on to the next. It is the very antithesis of patient-centered care. It is easy to understand how and why it happens, but it is not good medicine and should not be rationalized or excused.

I was also glad to see you explicitly note "the physician-patient power imbalance." We should never forget that no matter how stressed out, burned out, frustrated, and overwhelmed the physician is feeling, they always hold more power than the patient, and thus incur a special obligation not to abuse it. These doctors treated their patient badly because they could. They themselves are no doubt suffering, but the solution is not to punish the patient, but rather to heal themselves.

Dear --, please continue just to care about your patient, get to know them, and try to give them the care you'd want for your family members. This is not always easy, but will actually help maintain your spirit and your commitment. I have a feeling you already know this very clearly :-)

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I had the opportunity to work with a pediatric allergist and observe her interactions with her patients. There was one notable patient encounter that stood out to me. The patient was referred to the allergy clinic due to a variety of symptoms ranging from a possible peanut allergy to a complicated immunology syndrome called postural orthostatic tachycardia syndrome. What captivated me during this encounter was how the allergist was able to navigate a significant time constraint to make the patient and patient's family feel heard.

I observed that after introducing herself and myself to the patient, the allergist simply asked the parent of the patient to "tell her story". During the entire time the parent was explaining the story, the physician simply listened intently and did not interrupt. After the parent finished the story, the physician reflected on what was said and worked with the parent to come up with a detailed plan on how to best help the patient. I noticed that while the plan was detailed and extensive, very little would actually be done in this current visit for the patient.

Despite this, the parent was very satisfied with the visit and felt helped. This encounter taught me that a key component of patient satisfaction during office visits is transparency. The physician's ability to come up with a clear detailed plan for the patient and her parent to follow made them feel reassured in their care.

This clinical observation also reaffirmed the importance of a physician's role in listening to their patients. I observed that the physician did not interrupt the parent for at least five minutes. I noticed that the parent felt more and more at ease as she continued to talk. She felt cared for simply by having someone listening to her.

COMMENTS: --, I love that you saw - and understood - this wonderful example of balancing time constraints with still making the patient and family feel heard. I remember the first time a physician asked me to "tell my story," I almost feel out of my chair. I responded, "But you have my chart." He agreed, then said, "But I want to hear it from you." It was amazingly empowering and validating.

The point about non-interruption is also well-taken. Physicians feel under tremendous pressure to "move things along." Often they do this by cutting off the patient. Surprisingly, what seems like an efficient approach can lead to LONGER encounters as the patient tries again and again to be heard. Or the patient returns more often because she does not feel the physician listened. Listening is a therapeutic tool that can build trust, create confidence, and solidify the doctor-patient relationship. It's really worth using!

Your comment about transparency is insightful. In this case, it seems what you are referring to is the physician's ability to include patient and parents in the treatment plan, making them feel part of the process. This approach indeed does engender trust and is reassuring. Since it is the patient's wellbeing at stake, they deserve to be a "member of the team," treated respectfully and acknowledged for their expertise.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I can recall a shift in the emergency department where I was impressed with the quality of care provided to a patient. A patient came in with a fever and was not feeling well. The attending provided compassionate care to the patient and gave them extensive time to describe all of their symptoms. I could see the attending had an empathetic demeanor and despite being quite busy took the time to take an extensive history. I could hear the soft and understanding tone of the attending as they told the patient that they were going to receive the best care possible. I felt inspired as a witnessed the quality of care and passionate care being provided by the attending physician.

From this encounter I learned the true art of doctoring, and felt that I would someday like to emulate the quality of care provided by the attending I witnessed on that day. I could tell the patient was happy with their care and I even overheard them mentioning to a family member how grateful they were to have such a compassionate doctor.

COMMENTS: --, you did an excellent job of observing exactly why this was such a compassionate encounter. There's a lot to be said for the "intangibles" of communication - using a gentle tone of voice, creating the sense that you have all the time in the world, providing reassurance. As of course you know, patients come for care fearful and confused, trying to trust a bunch of strangers in white coats. It is often small things like body language, tone of voice, a calm, non-harried demeanor that create a sense of safety in the patient. The patient's gratitude for the compassion of this physician is evidence that, with a few thoughtful, kind touches, even in a busy ED, achieving a human to human connection is possible, and can have many beneficial consequences.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I recall a situation that I observed during my rotation in the ICU that struck me because of the way the medical team treated our patient and his family. I was surprised by the team's lack of attention towards the family, which to this day reminds me to practice mindfulness and compassion. The patient had just been transferred to the ICU from the general medicine floor due to septic shock. Soon after the patient arrived at his bed, several members of the medical team including two fellow physicians, a resident physician, and myself came to evaluate the patient at bedside. The patient was awake and fully oriented but appeared uncomfortable and in moderate distress.

Once the physicians decided the patient was medically stable, they decided to perform a bedside ultrasound exam of the patient's heart in order to rule out cardiac disease. One of the fellows, who was an avid ultrasonographer, led the ultrasound exam while teaching the rest of the medical team. As he scanned the patient and casually explained the images to the team, the patient's family walked in. Immediately, I could sense the family's worry as the daughter appeared to be on the verge of tears. However, the rest of the team did not seem to notice, as they did not greet the family as they entered. Instead, the fellows continued to obtain further images of the patient's heart, which had already revealed no abnormalities, for purely teaching purposes.

The fellow continued teaching, and I felt bothered that no one seemed to be paying any attention to the anxious family members while the medical team casually conversed amongst themselves. Finally, after several minutes, during a lull in the teaching, I quietly introduced myself to the patient's family who had been standing off to the side watching the exam. Then, as I proceeded to ask what the family had been told so far, the other fellow physician took notice and cut off our conversation, introducing himself and explaining the patient's status. The patient's children had many questions, and once they had all been answered, the daughter was left in tears, distressed about her father's odds of survival. The resident and I returned to the workroom. There she mentioned to me how she too had noticed the team's delayed lack of acknowledgement of the family and felt "bad about it."

Both then and now, I find it disturbing that it took so long for the team to finally address the patient's family. I realize that we practice in a teaching hospital and that part of the fellows' responsibilities as senior members of the team is teaching. However, I feel that the family members deserved to be greeted and acknowledged sooner, especially when they were clearly worried and the primary purpose of the exam had already been achieved. I also recognize that as trainees, it can be challenging to balance the never-ending demands of patient care with our obligations to personal learning and education, and that perhaps the fellow felt this situation was indeed a rare opportunity to provide valuable teaching points. However, I did not get that impression, and feel that there was simply a lack of concern for the patient's family.

And while I do believe that it is humanly impossible to feel genuine, deep sympathy for every single patient, much less the circumstances of their family members, I do believe that providers have a professional, if not human, obligation to show basic consideration and etiquette toward others, especially in non-emergent settings. I believe this encounter will make me a better physician by serving as a reminder to consider and recognize the immense fear and worry that patients and their families may have, and that my obligations are not only to learning and science but also to demonstrating mindfulness and compassion.

COMMENTS: "Basic consideration.... a human obligation." This is the heart of your essay, --, and such a valuable conclusion. Your insights and actions throughout are admirable. First was your sensitivity to the family's distress, which was either ignored or overlooked. The emotional intelligence you demonstrated here to the family's suffering is what will make you an outstanding physician.

Second was the fact that you, the medical student, took appropriate action where no one else would. You chose to greet and interact with the family. Interestingly, these efforts to acknowledge and comfort the new arrivals did yield an important shift, most importantly that the family received the attention and information they deserved; that the other fellow came over to the family; and that later the resident acknowledged that she "felt bad" about the way the family had been treated. I think these positive consequences were all a direct result of your taking the simple, yet brave, step that you did.

I also appreciated very much that your essay tried to see not only your own perspective and that of the family, but also the fellow's perspective as well. You carefully considered his possible motives and goals before concluding that, regardless, these did not justify the lack of response to the family. Doing so perhaps showed how easy it is to get casught up in misplaced priorities and forget the cardinal rule that patient and family must always come first.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

While rotating at Harbor UCLA Medical Center, I had the pleasure of working with a fellow in the Pulmonary Intensive Care Unit. During my rotation we had many severely ill patients and in my observations I learned many things that I will carry with me in my medical career. One of the first things I noticed was the amount of time that he spent with the patients and, equally as important, their families. Whenever there was a new admission to the ICU, he sat down with the patients and explained what he thought was going on, why he believed this, and what he felt they could expect over the hospital course. He was available for questions and was kind and compassionate throughout the conversation.

He also had the same demeanor with his colleagues, which I found very impressive. Oftentimes in the hospital, it feels like each service is trying to pass of work for the sake of avoiding it. Many times I have felt that different consult teams are passing around the responsibility to make it not their problem. When this fellow received consults he would take his time to talk through the case with the consulting team. If the patient was not a candidate for the ICU, he would still go and examine the patient. He would then give the consulting team recommendations for managing the illness and would make himself available if they had any questions. I will keep these experiences in mind when I interact with patients and colleagues in the future.

COMMENTS: --, one thing that struck me in your observation was the way this fellow provided a structure and context - he didn't just provide information, he created a framework. This is very important to patients and families who often feel at sea and lacking the big picture of what is happening.

I also like that the fellow behaved with similar care and attentiveness to colleagues from other services. Ideally, consultants and primary and everyone involved is working together for the betterment of the patient - but it doesn't always feel this way. Unfortunately, as you say, there is often a sense of different consult teams trying to foist off "work" (i.e., patients) on other services. Your fellow offers a shining example of someone working collaboratively with the consult team, examining the patient even when the patient would not be going to the ICU, and offering recommendations and insights to the consult team. To me, this is the epitome of good teamwork and good medicine. I'm glad you had the opportunity to see this physician in action.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I was rotating in the ICU at this time. There was a patient who came in following an auto vs bicycle collision, with multicompartment cerebral hemorrhages that were determined to be not survivable by neurosurgery. In essence, the patient was brain dead with some intermittent ability to overbreathe the ventilator. He was fairly young, and his family was based in the Midwest, and they were devastated when they received the news via phone from my senior resident. They caught the soonest flight they could and arrived at UCI the next day. I watched as my attending took the time during busy ICU rounds each day to spend as much time as the family needed to process what had happened, explain the physiology, and share as much information as possible. I was moved by the compassion of my attending, who connected with the patient's mother, father, and sisters, not ignoring their emotions but acknowledging them, and offering some personal stories of his own. I saw how he was able to lift the family's spirits from crying to laughing by sharing his own experiences, and empathizing with them in the face of such a devastating event. I saw how his own actions trickled down to the rest of the team: my senior resident as well took time during the day to sit with the family whenever they were around and discuss the clinical course, and explore the family's wishes, which included organ donation. My junior residents too took time throughout the days in order to comfort the family. It was encouraging to see such leadership by example, and firsthand witness the positive trickle down effect during my time on service with this attending physician. In my practice, I will remember that sometimes the best teaching and leadership comes not from lecturing or verbally explaining but simply modeling and showing through action the right way to treat patients and to act in critical, sensitive moments.

I was especially moved during this time because I was tasked with finding contact information for patient's family with only his name and his Midwest ID. I was able to locate him on Facebook in order to help the case manager and I was profoundly affected by how we shared many similarities and how many people cared about him. I felt a personal connection to this patient and was immensely appreciative about how my attending on service, and by extension the rest of the team, took care of him and his family, and it is something I will never forget.

COMMENTS: --, this story is tragic, but I agree it sounds like a wonderful example of how compassion and concern can help ease such a devastating burden as the loss of a loved one. In this case, the attending through his actions was able to help the family feel supported and understood.

You also make a wonderful point that the physician who leads the team can often set the tone - if they are abrupt and mechanical, this tends to affect the rest of the team; if they are compassionate and caring, the team will tend to follow along. I agree that setting an example is often the best kind of teaching - walk the walk, and others will be inspired to join you.

You also saw, I think, how finding a human connection with a patient is (usually) not an unbearable thing, but can actually lead to openheartedness and compassion for all that the patient and family must endure. By seeing our common humanity (which is not something to fear but rather to embrace), we can better understand their suffering, and then take the next step to help them through it however we can.

I agree this was a very moving encounter and something to hold in your mind and heart always as a source of inspiration of what a caring doctor and team can do.

CLIN OBS ART OF DOCTORING 2019-20

My clinical reflection comes from time that I spent in the dermatology clinic. I think it is good for me to reflect on this clinical experience because being completely honest, dermatology is not where my clinical interests lie and is certainly not a strong point knowledge-wise for me. As a result, I felt like my senses were heightened for paying attention to key details in patient-provider interactions since I found this component of the appointments to be the most interesting.

I should probably preface my experience with my personal experience, as this largely shaped my initial perspective of dermatology patient-provider interactions. During medical school, I had a full body skin check and was quite unsatisfied with the appointment. I knew that you have to be naked for your skin to be examined thoroughly, and also know that UC Irvine is a teaching hospital, but I was not expecting my bare skin to be exposed for an attending, research fellow, two residents, and medical student all to see in the confines of the tiny exam room. I left that appointment feeling a combination of embarrassed, violated, and annoyed and made a mental note that I would never do the same to a patient as a medical student, resident, or physician and would use common sense when it comes to determining how many bodies it would be appropriate to have in the exam room at once.

Anyways, it is with this lens that I approached the dermatology clinic. However, I was quickly pleasantly surprised by how dermatologists conduct business. Yes, I did see my fair share of skin checks with a few too many bodies in the room and could see from the looks on the patients faces that they too were feeling a combination of embarrassed, violated, and annoyed by how many bodies were in the exam room. Most appointments followed a different format that was quite refreshing. Unlike a primary care office where patients come in with a million concerns that the doctor needs to sift through and prioritize while typing up a note, refilling medications, and performing a full physical exam, most dermatological complaints were fairly focused, so appointments generally followed this format: anxious patient sits on exam table, dermatologist quickly looks at anxiety-provoking skin lesion, 99% of the time the skin lesion is nothing to worry about, patient is overcome with relief, dermatologist talks about patients life for the remainder of the appointment (often at least 10 minutes).

I was blown away by how well many of the dermatologists knew their patients! In many ways, I felt like dermatologists have this duel role as a therapist for many of their patients. In many cases, it seemed like the skin lesion that the patients were worried about was more of a manifestation of the other stressors in their lives and many dermatologists took the time to uncover this other stressor.

My overall takeaway from my observation in the dermatology clinic is that it is so powerful to get to know your patients if you have the time (and to become an expert in your field so that you can quickly cover the "clinical" side of an appointment and allocate the remaining time towards getting to know your patients). I could not believe how relieved patients looked after leaving the dermatology clinic—in many ways, they looked more relived and "heard" than most of the patients that I saw in the psychiatry clinic during my psychiatry clerkship. I loved listening to patient's stories and hearing about

their lives, and this experience definitely cemented my belief that getting to know your patients is in itself therapeutic.

COMMENTS: --, it is so cool that you chose to focus on a specialty that is not one you're choosing and does not actually have much interest from a medical standpoint for you. I think it is quite insightful on your part that this lack of interest could heighten your sensitivity to the patient-physician interactions.

I was also impressed by your awareness of how your own pretty negative experience with derm provided a skeptical lens through which to view the specialty. It is this kind of knowledge of our own biases and assumptions that can help us untangle our own reactions to situations so that we can see as clearly as possible.

To make a personal disclosure of my own, unfortunately I am in the 1% of patients who have a distressing finding (mostly squamous cell) whenever I see my dermatologist. In the last 7 months, I have had 5 extensive Mohs procedures, the last one taking 7 rounds and 7 hours. As you might imagine, such a procedure, although performed with lidocaine, is emotionally very stressful and physically exhausting. During each round, my doc talked to me about my kids and grandkids, my work, the differences in Jewish and Christian holiday celebrations, her residency training. She knows me well, and is a skilled surgeon who knows what she's doing, so she can relate to me on a personal level. This in turn reduces my anxiety and discomfort; and makes a rather grueling experience as pleasant as possible for both doctor and patient.

All this is to validate that any specialist can find a way to connect with the humanity of their patient. This is not only the "right" thing to do, but has immense benefits for the patient's healing and for the physician's wellbeing.

Keep listening to your patients' stories. They will be happier and more satisified and so will you!

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

Throughout the interview process for residency programs, I heard at length about call schedules, clinic characteristics, and resident benefits, but I rarely got a glimpse of authentic interactions between residents, patients, and attending providers. As I am nearing the time to decide where I want to spend the next three years, I realized that one of the biggest factors was finding a program where I would feel supported by my colleagues, both inside and outside the hospital. Therefore, I chose to return to one of the programs that I am considering highly in order to gain a more intimate look at this dynamic. I observed rounds in both the inpatient ward and neonatal ICU.

I was led on a tour by a chief resident, who narrated much of what we saw. The most interesting aspect of my observation was how the attending physician on the wards team positioned herself while the team was talking to a patient's family. The intern talked directly to the patient's father, with the senior resident positioned next to her. The attending had stepped back, out of the line of sight of the intern. This was intentional, my chief resident said, so that the intern did not fall into a trap of speaking toward the attending. Instead, the intern looked directly at the family, and if she looked toward a superior for approval, she would look towards her senior resident. The goal is to give each resident the utmost autonomy in decision making for their level of training. It was such an easy intentional move, a seamless and somewhat effortless decision on the engineering of physical space that allowed the intern to take the role of primary provider and senior resident the role of team leader, with the attending overseeing the transaction.

I walked away from this experience impressed with the ease with which the institution disbanded stereotypical hierarchies. In addition to the scene I witnessed at rounds, all attendings go by their first names, and white coats are not allowed in the hospital. I plan to take this lesson with me as I continue in my training; to emphasize each team member working at their highest potential, with collaboration and unity prioritized over medical formality.

COMMENTS: --, I am so impressed by how carefully you observed these rounds, and how much you learned from your observations. I particularly liked your awareness that the way the team positioned

itself in relation to the family "disbanded stereotypical hierarchies." (Such a great phrase!). In my view, one of the most important things a physician can learn to do is when to get out of the way. Of course, in many situations, the physician is at the center, but there are many times in clinical encounters and in teaching that the senior physician should step back and level the playing field. As you noticed, this helps learners take appropriate responsibility and practice their skills, whether medical or communicative. In clinical interactions, sometimes being quiet allows the patient or family to step up, ask important questions or express opinions or doubts. As you commented, one way of understanding what you saw is as a well-functioning team, where each member knows their role and as well as others' roles; and the team itself is organized so as to maximize everyone's potential. Wherever you go for residency, I can already see that you will carry these important lessons with you.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

One of the most powerful interactions in medicine that I have encountered was between a radiation oncologist and a cancer patient. During this clinic visit, the physician had to deliver bad news about recurrent cancer despite aggressive prior radiation therapy treatment. Regardless of mode or method of delivery, this is always a difficult moment for both physician and patient. What made this one so special however, was seeing how the physician navigated the language barrier and even through an interpreter, demonstrated such tangible compassion.

As he was delivering the news, the physician took the patient's hands in his. Looking directly in her eyes, he told her that he would be there along side the entirety of her cancer journey no matter how many treatments or rounds of medication she had to go through. Even the interpreter on the iPad screen looked teary-eyed in this moment.

When thinking about what exactly the physician did to demonstrate empathy in such a powerful way, I am reminded of the power of human touch. In that moment, what was demonstrated in the non-verbal was even more impactful than the words spoken. I hope to carry this with me throughout medicine, as I remember how powerful a simple yet kind touch from a physician can be.

COMMENTS: --, I'm so glad to have read this example of compassion transcending cultural and language barriers. With sufficient diligence, care, and attention, it is possible to deliver bad news humanely across cultural/linguistic differences.

This oncologist addressed a common fear in patients; i.e., that once treatment has failed, the physician will abandon them. It was so comforting to read of the way he reasured his patient that he would stay the course. I also think that, appropriately utilized, physical contact can be more powerful than words, consoling the receiver on a deep level that may go back to childhood. I agree completely with your point that, simply by taking his patient's hand, the oncologist conveyed his caring and commitment.

Reading about this encounter showed that we can always find a way to connect human to human; and we should never find excuses (language difference, no time) not to do so.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

One example of an interesting doctor patient interaction that I witnessed was when we had to deliver some bad news to a patient in the neurology clinic. Before we saw the patient, the physician I was working with gave me a brief history of the patient's progress with brain cancer. We then moved to the new radiology reports generated for that patient to see if the cancer had continued to progress. Unfortunately, the reports showed that there was still cancer present, and that it was invading the patient's brain in a way that would be very difficult to treat surgically. I was interested to see how the physician would handle delivering the bad news.

On entering the room, the physician greeted the patient as normal, and they spent the first few moments catching up as they had a long history of working together and it had been several months since their last appointment. Although the conversation was lighthearted, you could see that the patient clearly was anxious to discuss the results of their imaging study. Eventually, the time came to deliver the news, and the physician use some elements of the SPIKES protocol to set the scene, which the patient immediately picked up on, knowing that bad news was coming. When the physician delivered the news, the patient was prepared, and although we discussed how this would severely affect the patient's life and career, it was clear that the patient felt comforted in the way that the news was delivered and the additional time that was provided for questions.

This interaction was beneficial to me in my own development as a physician because this was sadly not the first, nor the last time that this neurologist would have to deliver bad news. I was able to see firsthand how he approached this difficult topic, and he shared with me much of the wisdom he had learned through working in his field. As a future emergency medicine physician, I will undoubtedly be called upon to deliver bad news to patients, and I am glad to have had this opportunity to learn from an attending with much experience how to make it as comforting as possible to my future patients.

COMMENTS: Dear --, I am glad you mentioned both the SPIKES algorithm and clinical wisdom. Both, I think, come into play in breaking bad news (which some physicians prefer to call "bearing bad news," as it sounds a bit less harsh than the "breaking" that inevitably occurs in the aftermath of devastating information). SPIKES is a great model, and being familiar with its steps (including the essential "warning shot" to prepare the patient and/or family) provides a useful structure to ensure nothing is missed. However, for an algorithm to be truly effective AND compassionate, it must be infused with clinical wisdom. That is based on your experience, your ability to be present in the face of suffering, and your trust of your human instincts. This neurologist clearly drew on his personal knowledge of and relationship with the patient to adapt his delivery to this particular patient's needs.

Finally, you make a very important observation that, while nothing can take away the anguish of a terminal diagnosis, HOW this news is presented can provide comfort and hope (not hope of cure, but hope of guidance and care and above all commitment on the part of the physician to walk beside the patient until the end). I know this experience will remain with you and remind you that the way you interact with the patient at this pivotal moment in their life can indeed bring them comfort and help them find the courage to face what lies ahead.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

It was the first day I have ever worked with this attending and it was also his first day back on service. I tend to get a little bit anxious meeting a new preceptor because on one hand, there is a good chance they are going to be nice and awesome, but there is always a small fear that they may not be pleasant to work with. Within minutes of meeting, I could tell I would enjoy working with him. He had a calm demeanor and spent a lot of time teaching me right away as we rounded on patients in an educational and effective way. It was a busy service and he had a lot to do, but he always made some time to provide a teaching point. Thus, I felt very comfortable asking him questions and talking throughout the day.

Something else that struck me was that as soon as nurses and ancillary staff saw him, they all became very excited and expressed how glad they were that he was the specialist on their service. They immediately told the patients how lucky they were that he was the doctor caring for them this week. I think it means a lot when other staff members speak highly of another co-worker voluntarily because it shows the type of person and colleague they are. This is the type of leader and physician I will strive to be. A good clinician with even better interpersonal skills and with their staff.

I really appreciated his communication with the pediatric patients and their parents and families. He explained his thought process and reasoning in simpler terms that they would understand. He often said, "Let's make this decision together." "I'm going to need your input" "What do you think?" I think it was great that he made the parents feel like they were part of the decision-making process so that they understood what the plan of care of was and that we were all part of a team. The next few days, I would notice these positive characteristics and qualities in the attending that he consistently showed with all the patients, nursing staff and other healthcare staff. I hope to emulate these qualities and integrate them in my future interactions and care for patients.

COMMENTS: --, I liked the way you paid such careful attention to what made this attending so special. First you noticed the way he treated you, committed to teaching you and appreciating your role as student. Second you had respect for the delight of the nurses and staff when this attending came onto service. Third, you noticed this attending's superb communication skills. The examples you recounted are especially valuable, because they illustrate important principles in communication: 1) Transparency - sharing not only the endpoint, but something about the steps along the way, so that parents can evaluate them. This increases buy-in to the treatment plan 2) Inclusiveness - this is shared decision-making, which this attending seemed very comfortable at achieving.

Finally, you valued this attending's consistency, as do I. I've seen some physicians who are kind and caring toward patients, but who treat staff or students in a demeaning, disrespectful way. A truly excellent physician does not behave one way with patients, another way with staff, and yet a third way with learners. Instead, because their behavior is informed by deeply held values, they behave the same with everyone who crosses their path. This is a person whom patients, nurses, and students alike will trust and admire, as you did. --, you chose a good role model and I hope this physician will continue to inspire you as you grow as a physician.

ART OF DOCTOROING 2019-20 CLINICAL OBSERVATION

When I was observing and shadowing a PM&R attending in outpatient pain clinic at Gottschalk Plaza, Dr. X received a call from a patient asking when she can set up an appointment as she was unable to walk, requiring a wheelchair as her left lower extremity was swollen and in severe pain with reduced range of motion. Originally, she had been seen for osteoarthritis of the left knee months ago and had received a Synvisc injection at the time, which is synthetic synovial fluid injected into the articular space for patients with arthritis.

My attending went above and beyond, telling her to come in in a few hours that same day because she would MAKE time for her even though she wasn't on the schedule. Once she arrived, my attending brought her into a private room, placing pillows underneath her leg and reclining it to elevate it, and asking me to get ice for her leg. She also pulled up a paper from the literature to show the patient; she reviewed it with her to explain the complications of Synvisc and how it doesn't work for every patient. Additionally, she did a thorough physical exam and noticed that there was abscess-like fluid at the knee. Instead of just injecting her with more anesthetic or pain medication, she decided to use diagnostic fluoroscopic arthrocentesis to analyze the joint fluid using x-ray to confirm location after each adjustment of the needle.

I got the opportunity to aid with the interventional procedure and Dr. X wanted to provide her with relief so she also drained the joint to reduce the amount of fluid causing her pain. She gave her empiric antibiotics and rushed the cultures of the fluid to the lab. Within an hour, microscopy and a blood draw was able to determine that there were bacterial organisms in the fluid causing joint infection and septic arthritis. My attending went the extra mile and made sure to rule out gout and pseudogout as well.

What struck me the most was the calm demeanor she exuded. I will definitely carry the methods used to provide reassurance as the patient had anxiety regarding affording the procedures she was receiving into my future career. Similar to how my attending walked the patient through every step despite the severe and debilitating pain, I will show my future patients support so they don't feel alone during any painful or invasive procedures, playing serene music and explaining to them each step.

Furthermore, I have vowed to follow up and follow through with my patients, being diligent and checking on every possibility. I felt like my attending showed true compassion by explaining the injections to the patient; I will ensure my future patients have all the information they need and so that they can give consent and be fully informed with what they are going through. I learned that the patient's comfort is also paramount, as they will be more likely to see their care provider as a teammate that they can work with to formulate a plan for their management. Establishing this rapport will aid in encouraging compliance to lifestyle modifications and treatment adherence.

COMMENTS: --, I know Dr. X slightly and she does strike me as a very compassionate physician. This example to me seems a perfect example of compassion-in-action. The physician took many concrete steps to show the patient that she was concerned about her - bringing her in immediately to clinic, making her as comfortable as possible, taking care to reach a proper diagnosis, and in all ways going that proverbial extra mile to ensure the patient was receiving optpimal care. Although we don't

always think of it as such, thoroughness is a way of expressing compassion, because it conveys that the patient is worth the doctor's time and thought.

You also noticed that, throughout this encounter, which was probably painful and upsetting to the patient, the doctor exuded a calm demeanor. Learning how not to mirror a patient's agitation, instead retaining a compassionate, patient attitude, goes a long way toward creating the sense that although problems are arising, the physician knows how to handle them.

Your commitment to follow-up, diligence, thoroughness, and transparency in explaining what is happening is wonderful. I agree that such an approach will more often than not result in a sense of being on the same team with your patients. You are quite right that patients fear going through difficult procedures and diagnoses "alone," with a doctor who doesn't really care about them. Feeling that their doctor is "walking with them" no matter what is happening or what lies ahead builds trust and helps the patient relax. This in turn makes the doctor's job easier. Everyone wins - the physician is less stressed and the patient gets the care they deserve.

Art of Doctoring 2019-20 Clinical Observation

My clinical observation will be about my morning rounds at the pediatric ICU in regard to my patient, a baby boy who's been discovered with an incidental adrenal mass in the setting of emesis, lethargy, and severe hyponatremia. His hyponatremia was stabilized, although etiology is still being thoroughly worked up, and the mass has recently been biopsied by IR. On the differential, in broad categories, remains neoplasia, infection of unknown etiology, gland hypertrophy/necrosis. This morning we showed the MRI images of the mass to the parents and what the likely outcomes of the biopsy would entail. Dr. L frankly told them that this was most likely a tumor, neuroblastoma, which would require chemotherapy. There was a high probability that may indeed be a tumor, but the biopsy is still pending. He briefly that the prognosis for these types of pediatric tumors are fair/good. He gave a nod signifying his condolences and walked toward the next patient room.

Dr. E, part of the Endocrinology team, walked into the room second to discuss his portion of the workup. However, when we walked outside the room, he seemed concerned and tapped me on the shoulder."Is this your patient? The mom is inside crying. You should make some time today and go inside and give them some of your time. Let me give you some advise: there will be a lot of teams that walk in to your patients room and drop bombs and leave. It's your job as the patient's primary to let them know your there and to make sense of it" Dr. E said.

I excused myself from the next patient presentation and walked into the room now. I chatted in depth with the parents about going about this workup process step-by-step and not to quickly fall into the 'what if' scenarios. I explained although it's scary to hear the cancer word be death it would be a disservice and dangerous not to mention the real possibility. I allowed them to ask as many questions as they needed and offered to give space when desired. After that morning my patient rapport was fully maximized and the parents looked at me as their primary doctor, even forgetting that I introduced myself as the senior medical student.

This experience taught me not to shy away from the important conversations and not to assume that someone else will have or will do it for you. I learned even in the most busy of work schedules time for patient interactions and counseling is a needed component. The workup and treatment is only part of the management.

COMMENTS: Wow, you did a fantastic job of picking up the pieces! And your conclusions are absolutely correct: Too often in the world of modern medicine, with multiple physicians, consultants, and teams involved in a complex case, everyone thinks "someone else" will do the heavy lifting of helping patients and families process difficult emotions. Often this translates into "no one."

Although Dr. L did a competent job of delivering information, and in my view at least made the right call by introducing the possibility of cancer into the parents' thinking (since there was a high likelihood, this might prepare them for what might lie ahead), but they fell short in not acknowledging the immense suffering that this information produced. This is what "owning" your patient means - not simply disseminating facts, but sticking around for the consequences of those facts.

I admired Dr. E for understanding the emotional dimension of the situation, and for guiding you in the direction of whole person care. I admired you for excusing yourself from the next patient and returning to that room. That could not have been easy. From your account, it sounds as though you handled this painful situation really well, listening to the parents, giving them space to ask questions, urging them not to get too far ahead,

and above all, letting them know that somebody cared about what they were going through and would be there for them. Well done!

As you know, these conversations are hard, of course for the parents, but for the physician as well. Nevertheless, there can be real satisfaction in knowing that you did not abandon your patients emotionally, as Dr. L inadvertently did by leaving the room, but rather stayed the course. You gave these parents a great gift, not only of additional understanding (very important), but also a sense that they had someone on the team who actually cared about them.

In this moment, you did indeed become their primary physician; and the trust and confidence you engendered I'm sure created a positive context for whatever comes next for them and their baby.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I am passionate about family planning because I feel it is extraordinarily patient centered. Whether the decision was an easy one for the patient or it is one they grappled with for weeks-the role of physician in this space is to validate and safely achieve the desired procedure for the patient. The interaction with patients in this space can sometimes be very emotionally charged, especially if it was a planned and desired pregnancy. I have learned a great deal from my current preceptor, Dr. H.

Last week we had a couple come into clinic for options counseling after it was discovered the pregnancy had a genetic abnormality. The patient was visibly emotional and her husband was angry. I immediately noticed he was grieving and he was sitting deep into grief stage of anger. I spoke to them and gathered more information; the husband was sulking the entire time. He was particularly enraged when I asked how he was doing, answering rhetorically, "How do you think I am doing? You have no idea how I am doing!" I told him he was right, I did not know how he was feeling but we were here to support him and his wife through this tremendously horrible experience.

After I presented to Dr. H we walked into the heated room. Her interactions and approach with this couple is a visit I will definitely refer back to in my years to come. She began by saying, "I'm sorry. I wish we didn't have to meet under these circumstances." In sad and uncomfortable situations, it often feels easier to talk around the issue; be professional and explain the next steps, etc. Dr. H carefully crafted her words and gave space to that uncomfortable feeling. She told the couple, "I know this is not how you thought it would end and this is not fair," and "You have every right to be angry." I watched the husband slowly start to dismantle his anger and grieve. His body language changed and he began to comfort his wife instead of sitting with his arms crossed in the chair.

This interaction taught me that in those emotional moments during a family planning clinic, it is okay to state the painfully obvious. Saying sorry and reiterating this unfortunate feeling is validation. In family planning, more commonly we validate the patient by reiterating they know what is best for them and their life. When our patients are validated to make the decision best for themselves, they open up and a provider/patient alliance is formed. This interaction showed me another way to validate my patients grieving the loss of a desired pregnancy. Validating that they are being a parent by making this difficult decision to terminate to avoid pain and suffering. Dr. H stated "This feels unnatural, but you know what is best for you and your child" and in the end each patient is in the center of the visit, making the decision. Dr. H is skillful at validating and giving the patient the power and autonomy to make the best decision for them.

COMMENTS: --, I have great respect for the way you handled the husband's anger. First, you recognized that the anger was really a symptom of grief. In fact, anger is often manifest when covering some more difficult emotion - grief or fear. This does not justify inappropriate expressions of anger, but it does help us understand what is going on with the patient and not take it personally.

Secondly, when the husband attacked you for your question, instead of responding defensively, you agreed that he was right (you did not know what he was feeling), but reiterated your support for him and his wife. This is a wonderful example of not allowing the patient's emotions to determine your emotions, but allowing your commitment and compassion for the patient to continue to be expressed.

Everything you observed about Dr. H's approach in this distressing situation was very insightful. She expressed regret and a wish that they were meeting under happier circumstances (do you remember Dr. X's point about expressing "wishes" for things that the patient desires but that cannot be?). Instead of jumping right in to "the plan," and avoiding sorrow through instrumentality, Dr. H overtly expressed some of the feelings this couple must have been wrestling with - anger at the horrible unfairness of this outcome. As you said so well, she "gave space to uncomfortable feeling."

--, you are so right that to be an effective physician (in family planning situations and many others as well) you must be ready to deal with your patients' emotions - and your own. This is sometimes not easy, but I think you will find, if you haven't already, that there can be a great sense of privilege in sharing such moments with patients.

Finally, your point about validation is really perceptive, and one I had not thought about in this way. But it makes sense to me - how wonderful to see a physician who, even at such a dreadful moment, sends the message, "You are still the parents. The feelings you feel are those of parents. The decisions you make are acting as the parents." The trust of the patient and spouse that Dr. H. expressed was indeed an example of validation, albeit under a very different set of conditions than you usually face in the family planning context. Thanks for noticing this, and for highlighting in this way that preserving patient power and autonomy plays a key role in effective family planning.

ART OF DOCTORING 2019-2020 CLINICAL OBSERVATION

During my surgery rotation as a third year medical student, I spent two weeks on the plastic surgery team. The majority of our procedures were breast reconstruction for patients with breast cancer status post mastectomy. The interaction between one of these patients and the medical team in the clinic significantly stood out to me. There were joyful tears and a renewal of identity that was beautiful to witness.The patient was a woman who had a history of breast cancer and had a double mastectomy with radiation treatment and was now in remission. However, she struggled with her sense of identity as a woman because her breasts were severely scarred and essentially nonexistent. She had a latissimus doris flap reconstruction performed in each breast via two separate procedures. I saw the patient in clinic as a post-op check after the second procedure.

The surgeon entered the patient room with a huge smile on his face and arms open wide to give the patient a hug. She had an equally wide smile on her face and was more than happy to hug him. The first thing she said was, "Thank you! I feel like a woman again!" She had tears of happiness running down her cheeks. The surgeon proceeded to examine the patient and she was recovering very well from the procedure. The patient explained that she was extremely happy and felt like she had her normal identity once again. She struggled to look at herself as beautiful when she had no breasts and a scarred chest, but now she proudly felt like a woman again.

The surgeon's reaction was pure compassion. He was kind and respectful when the patient cried and then he was very animated and excited when the patient was excited. He reciprocated her emotions which really helped him connect with her. This is what I learned from this clinical observation. One way to connect better with a patient is to match the patient's emotions. If the patient is sad and grieving, show compassion and it's okay to express sadness with the patient. Vice versa, if the patient is very happy and excited, then the physician should be happy and excited as well. This helps the patient connect with the physician because they see that their relationship matters.

COMMENTS: Hi --, there are a couple of aspects of your reflection that struck me. One is the power of medicine to restore not only the body, but a person's identity and sense of self. Just as you point out about emotions, taking the lead from the patient is critical. Not all women want or need breast reconstruction, and surgeons should not assume this is the "missing piece." However, for women who feel mutilated and incomplete as a result of breast removal, reconstruction can be life-altering as you saw with this patient.

Regarding emotions, in so many cases there is definitely a place for the feelings of both patient and physician in the exam room. Imagine feeling intense emotions - joy, sorrow, relief - in the presence of a robot. It would be awkward, embarrassing, disappointing, sad. When the physician mirrors the patient's emotions - takes joy in the patient's happiness, is willing to bear a small piece of their sadness - the patient feels less alone. Their joy is heightened and their sorrow is softened a bit.

This emotional mirroring is a good example of presence - the physician is fully in the moment with the patient, while retaining a little emotional space so as not to be overwhelmed by the patient's feelings. You had the good fortune to see a beautiful illustration of this with this breast surgeon.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

There is a physician at UCI that I have worked with extensively that I have learned a lot of from. First and foremost his ability to connect with his patients is remarkable. He always makes sure to pay attention to the details of the patient interaction and takes a very systematic approach towards it. He introduces himself in a calm manner, sits down on the patient's bed, makes good eye contact, and makes sure to engage the patient in a way that empowers them. What is even more impressive is that despite the fact that he does this extremely well, he still elicits feedback from his less experienced team members regarding how he could improve these interaction and takes steps to incorporate that feedback into his practice.

I learned from him the importance of humility no matter what stage of training you are at. Because of his humility and his constant willingness to grow, he earns the respect of both his team members and his patients. As a result other members of the team also feel the needs to do the same. He spends an extensive amount of time with patients to answer all their questions and to express compassion towards them. Even when his patients become upset and speak in a rude manner to him, he accepts it and cuts them slack because he knows that they are going through a difficult period. He has shown me that good bedside manners is not as innate as one might this but rather requires a very conscious effort and practical steps to make the patient feel that they are cared for.

COMMENTS: This attending sounds very impressive! I especially noticed that he finds ways of interacting with his patients that "empowers" them. Illness is extremely disempowering - patients often feel terribly helpless and out of control. Helping them to regain some sense of power is a great gift.

I also found it admirable that this attending would ask his team for feedback about not the medicine but his interactions with the patient. That is truly rare, but shows his dedication to continuously improving his communication skills. I think perhaps this is one example of this attending's humility - no matter his level of experience and status, he seeks out the perceptions of others and is always focused on doing better.

You make an excellent point that when the team leader prioritizes communication, personal growth and self-improvement, the rest of the team will usually adopt these goals as well. This is a powerful way of building a highly functioning team with a patient-centered orientation.

Finally, this attending's behavior is an excellent reminder that the patient's behavior need not determine your behavior. Just because the patient is rude or upset does not mean the physician should respond in kind. When you take such behavior personally, it is naturally to want to defend yourself. When you interpret this behavior as emanating from the fear and loss of control the patient is experiencing, it becomes easier to act with compassion and concern.

You chose a great example of a physician role model, and I'm sure his example will be imprinted in your mind and heart to help you become the best physician you can be.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

My brief observations took place in a family medicine clinic, with a physician who had incredibly happy patients, but also had some clinical methods that didn't exemplify what we had learned to be best practices. In the time that I spent observing him, I had many patients who would bring up to me what a great physician this doctor was, and that I enter my career I need to do my best to emulate him. He ran his practice like a business, and customer care was at the top of the priorities. Patients were seen on time, and he always left availability in his schedule to fit patients in for same day appointments. They knew that if they arrived at 1:00 for their 1:00 appointment, they would be on the road by 1:30 - something that is fairly rare in today's world of medicine. He responded to every patient email within hours including over the weekend. He was jovial and generous with the patients, telling them about his life story and personal interactions with the medical field as a patient and as a family member. This helped every patient feel like the doctor was his friend and creating a deeper patient family relationship.

But I also saw what he gave up in order to create this fast paced, scheduled environment in which he had time to he chatted with patients about their lives outside of the current problem. He minimalized many of the parts of clinical care that we have learned to be critical in medical school. Physical exams were often cursory, with jokes along the lines of "I'll listen to your heart to make sure you still have one." Referrals to other physicians were given out to most patients without any work up, including simple things like moles that many other primary care physicians treat on their own. He rarely asked questions outside of the patient's chief complaint or dove deeper into a problem than required. He chose to prioritize treating patients for the problems that were bothering them and keep them happy.

This was a really interesting experience because it showed an opposite side of a spectrum of happy, satisfied patients than many we see in the world of academic medicine. I have worked with many primary care physicians who ran over time with nearly every patient, but were caring and methodical. These physicians asked questions to find the problems that patients had, but might not have brought up initially. But the physicians often had to miss lunch to catch up on clinical care, and while their patients often loved them, I also many times saw them become antsy and unhappy has we ran an hour behind.

Thus, what I learned from this experience that you are always going to have to give up something. You can be fast and fun, fitting nearly every appointment within the time insurers give, but you aren't going to necessarily have the time to discover the deep problems. To me, it was giving up too much. As I continue in my career as a physician, I will be a better doctor by acknowledging time and do my best to be fast, but I do not believe it's in the patient's best interest to give up complete physical exams or thorough care. Referrals can quickly be given but make patient care another physician's problem, and also take weeks to month to help solve the problem, so need to be reserved for things that are actually outside of scope. For me, it will be important to find some middle ground.

COMMENTS: --, this was a fascinating and really thoughtful essay. What you realized is that patient satisfaction, which has become such an important metric in healthcare delivery, is a complex construct. I agree with you - medicine is not a "service" like getting your hair done. It is not only about keeping patients happy, but doing what is in their best interest. This means keeping some

patients waiting to adequately address the problems of other patients. It means not ordering tests or making referrals or prescribing medications simply because the patient asks. Good medicine is not about pleasing the patient but taking respectful, compassionate, and thorough care of the patient. You can and should care deeply about your patients, but your role is not simply to execute their desires.

There is some interesting research with cancer patients that shows patients are MORE satisfied with doctors who do not speak honestly about their prognosis, who beat around the bush, and who give them what we would call false hope. The doctors are telling these patients what they want to hear, but they are not being good doctors.

I think, as you conclude, that you can follow standard of care practices while also being empathic and compassionate - and setting limits when appropriate and disagreeing with patients when it's in their best interest.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

On the interview trail, many programs schedule time for applicants to attend hospital rounds during our interview day. I think that this is an interesting choice, especially in children's hospitals, given that all the applicants are dressed in severe navy and black suits and must trapes through the wards in herds. Occasionally, I would catch a glimpse of our group's reflection in a window or elevator door and be reminded of just how intimidating it must be for children and families to see a group of formally dressed people wandering outside their beds. Our appearance starkly contrasts with the colorful paint and murals of animals or friendly characters that coat the hospital walls. It also crossed my mind that pediatricians trade their doctorly white coats for stethoscope toys with flashing lights and high-pitched sounds, and in general pay a lot of attention to presenting themselves to patients and families in a way that is warm and less "doctor-y." In these moments of roaming the wards, I made note of just how important dress and self-presentation is in every facet of medicine and also was wishing I could trade my suit and heels for some mickey mouse scrubs.

At one particular program, I was assigned to spend an hour with a general inpatient pediatric team for morning rounds. At this point in medical school, rounds are not a rare experience, but this day felt different for one large reason: My purpose on the team was not to further patient care or provide education or follow-up planning to the family. I was not there to learn the pathophysiology of apneic spells, or to suggest a treatment strategy. It was not my role to help the team uncover this patient's previous health history or talk to a social worker. I found it challenging to embrace my role as simply an observer of team dynamics and resident training. I noted how the team seamlessly worked together to understand a patient's history. I heard of the social challenges that this family faced and the difficult conversations that had occurred yesterday, while internally assessing their levels of compassion and understanding. I tried to decipher how happy or overworked the residents were and kept my ear attuned for teaching during rounds. But I had to continuously remind myself that in this moment, I should not be focused on the medical issues, but instead my goal was to assess the training environment for my future residency training.

As we walked into a patient's room, I immediately felt out of place and out of my element. In part because I stood out as the only member of this team dressed in a formal suit that likely was sending the signal of "powerful person." In contrast to the message my suit was surely imparting, I actually was the least important person to the family on that team. In fact, I felt personal dissonance for even being in the room when I had contributed nothing for the treatment of this patient. The senior resident introduced me as a visitor to our patient's angry mother, who batted her long eyelashes in aggravation. I was ready to melt away or at least throw on my invisibility coat right then and there. It was clear that the mother of this patient was unhappy with the care her son was receiving at this hospital.

I watched and listened as the resident and attending dodged accusations and bullets for the next 20 minutes. In this strange circumstance, I began feeling as though the attending physician was becoming concerned about my interpretation of this situation - that I, as an applicant, may view this training program as lesser because this family was so upset with the care. Now I began to sense that the consoling and negotiations were not only for the family's benefit, but also mine.

The two linked but separate goals of 1). good patient care and 2). showing applicants the quality of the program, were suddenly two competing ends. Upon reflection, I realize the dangers of trying to

“kill two birds with one stone” in that if that stone misses, two birds get away. In this case, I felt that neither the patient nor I was satisfied with our experiences. I don’t think quality and compassionate patient care should ever have to compete with other demands of the hospital or training program, however, unfortunately that is not the reality of the future of medicine.

COMMENTS: Dear --, I wasn't aware of this practice of rounding while interviewing! It's very perceptive of you to think about how all these dark suits and formal attire might affect peds patients. I agree completely that any program encouraging hospital rounds should provide child-friendly scrubs!

The performative aspect of rounds conducted in the presence of interviewees that you teased out so perceptively is indeed troubling. You parsed this excellently --: by "merging" the two goals, neither was satisfied completely. The focus of the encounter shifted, at least i part, from resolving complex parent/team dynamics to impressing applicants and "proving" compassionate care.

This event made me wonder about other circumstances the team may be in performance mode, at least in part - any time there is an observer from administration, or perhaps even during some consults. It is also true that attendings may "perform" for residents and students; and students and residents certainly perform at times for attendings. It's an intriguing and disturbing phenomenon because as you astutely note, it deflects from and may subtly distort patient care.

--, I thank you for pointing out this phenomenon, something I hadn't really thought about previously. However, it is now on my radar screen!

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

For my clinical observation, I decided to go back and observe one of my mentors from undergrad who inspired me to go to medical school in the first place. He works at a small community clinic and I wanted to use this opportunity to visit and catch up, as well as be reinvigorated by someone who's practice style always struck me as the ideal to strive toward. I was not disappointed upon my return. Everyone I saw Dr. X interact with from his front office staff to fellow physicians, and of course the patients, he treated with the utmost respect, and this made for a pleasant work environment where everyone worked as a team. Beyond this, there were two major aspects of his practice which I admire about him, which it was good to be reminded about after all this time.

The first is related to how large of a role his faith plays in his life. He is a devoutly religious person who is heavily involved with his church. I myself am not at all religious and often think of it as being at odds with a doctor practicing good evidence-based medicine. This is not the case with him at all, as he is somehow effortlessly able to balance his personal beliefs with doing what is best for the patients. What I hope to remember from his practice though, is how important faith is to so many patients. While it is something I often overlook when talking with patients, he gently broaches the subject with many of his patients who are struggling with their disease, and you can see the lights go on in their eyes when they realize there is a support system for them, both internally and externally, which they are already familiar with. Going forward I will try to remember how large a role spirituality plays for many patients and that even though I myself am not spiritual, I can, and should, address the spiritual side of my patients as well.

The other factor which seems to set his practice apart from others I have seen is the way he draws on all aspects of his past to really connect with his patients. Many clinicians I have seen, tend to focus merely on the disease and treatment of the patients, without trying to connect with them. Similar to the way he draws on his faith as a way to connect, Dr. X also uses all of his past experiences to establish real relationships with his patients. I have seen him do this through speaking about his hobbies, his travels, his family, and even more removed things like the hobbies of his friends, just to show that he sees his patients as real people outside of their medical issues. In my future career in anesthesia, I know I will need to establish quick relationships with my patients to put them at ease during a particularly scary day for them, and I hope to be able to draw on my experiences to quickly connect with my patients in the same way.

COMMENTS: --, how cool that you went back to your old mentor. It sounded like the encounter fulfilled all your expectations and I'm sure he was very touched by this as well.

Your point about faith, both in yourself and in future patients, is a very interesting one. In terms of your own faith, although you say you are not religious, you probably have faith in something - in science to help make the world a better place, or in family to see us through, or in the goodness of people - something! This is your faith that can be just as sustaining as a religious belief.

In terms of patients, I agree wholeheartedly - religious faith can be a comfort and a sustaining force, and can help patients come to terms with illness. Patients can often receive support from their faith communities and consolation from their pastors or other religious figures. Attending to this

dimension is an important part of whole-person care, and it's wonderful that you are open to that as a physician.

What you say about Dr. X's ability to connect with patients is beautiful. As you write so perceptively, he wants to let his patients know that he sees them "as real people outside of their medical issues." We all want to be seen and heard as our unique selves, not some manifestation of disease. A physician who extends this sort of honoring to his patients is a rare and precious gift. They will benefit immeasurably from this person-centered approach and, perhaps surprisingly, so will the physician, for it is in human connection that we find our greatest rewards.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

When on my radiology rotation recently, I was planning how to schedule shadowing a physician in another department for this assignment. After all, how many "interactions" are even existent in a specialty like radiology? (Can you guess already that I did not apply to radiology this year?) I'm writing this now because I was pleasantly surprised by the incredible teaching going on around me nearly constantly. Yes, much of it was focused on what we were actually seeing in the imaging. But there was so much additional discussion that was encouraged by attendings regarding the patient's history, their level of discomfort, how concerned the consulting team sounded, and the prediction of surgical outcomes. One attending had obtained his Ph.D. in biophysics prior to attending medical school and even talked about the relation between this field and radiology to nail teaching points about a case, and to make broader generalizations regarding medicine as a whole. This was particular impactful as it left this medical student much more interested in viewing the x rays, CTs, and MRIs once it felt applicable to my future practice.

Additionally, I began my experiencing assuming what many of us probably do about radiologists: that they 1) dislike human interaction and 2) lack the social skills necessary for adequate bedside manner. I mistakenly attributed these stereotypes to a misunderstanding of my own, that they lacked empathy. it is easy, after all, to feel empathy for a patient in pain when you see them in person. It was striking, however, how viscerally these radiology attendings and trainees reacted to 2D, impersonal impressions of injury. The patients were treated with the utmost respect even when they were not (or never would be) present.

COMMENTS: This is a lovely essay, --, because it both breaks stereotypes about radiologists while acknowledging your own. I agree with you that it is unfair and reductive to dismiss radiologists as lacking in empathy and disliking human interaction. They may be more comfortable with a doctor-patient relationship at one remove, but it is important to recognize that, for a good radiologist, this is still a relationship. In conversations with radiologists, my takeaway has been that they have ways of keeping in mind the patient at the end of the xray, CT, or MRI.

That said, I think that, because of the relative remoteness from direct patient care, the specialty should pay attention to this issue during residency. I ran across a study that found that, simply when a picture of the patient was attached to the imaging, the radiologist spent more time and provided more thorough evaluation than for those cases without a picture. This suggests that it is important to help doctors in non-patient intensive specialties like pathology or radiology find ways of staying connected to the human dimension of their work.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

During my months on UCI's inpatient medicine service I observed many encounters that taught me a number of lessons and skills that I will carry with me into residency. One encounter in particular stands out as especially touching and memorable. Our patient was a friendly 70-something year old man with a history of bladder cancer who presented with significant back pain. His sweet wife and his cooperative daughters were often at bedside, and you could just tell everybody was dreading the possibility that this might be what they feared most- this could be cancer, again. After a few days of numerous labs, imaging tests, consults, biopsies and lengthy discussions with other services, we arrived at our conclusion. Our patient had a second primary cancer, and it was an extensive renal cell carcinoma that was surgically inoperable because it encased his aorta.

The next morning we went in to tell the family the news. Everyone gathered around the bed- the daughters held their mom's hand, the mom put her hand on her husband's shoulder, and he just looked at us with a peaceful smile, as if he knew what was coming. My attending and senior resident pulled up chairs to be on the same level as the patient and his family. They put all clipboards and paperwork aside, they were fully present in the conversation. They spoke slowly, clearly, paused to let the information settle, and then offered support and comfort in this sad time. There were sniffles and tears and quivering lips, and I felt so sad that these people who have been nothing but kind over the past few days had to go through this. It seemed totally unfair, and my heart broke for them.

From this experience I learned the importance of how the delivery of bad news can make a horrible situation more bearable for both parties involved. My attending and senior were eloquent, knew when to pause, and knew how much information to offer at this initial conversation. I'm sure this ease and insight comes with practice, but it taught me to not shy away from difficult conversations like this one because each one will teach me an important skill that I can carry to future conversations.

COMMENTS: --, you put the essential lesson here perfectly: "how the delivery of bad news can make a horrible situation more berable for BOTH parties involved" (emphasis mine). This is SO insightful. Medicine will not be able to solve or fix the problem of extensive renal cell cardinoma that is surgically inoperable. So everyone, doctors, patients, family, feels helpless and inadequate. How can these feelings be softened and even transformed into something better?

What doctors CAN provide in such a moment is their presence (as you note); and that the medical team is there to continue to help (with guidance about future decisions, pain management etc.). Nothing medical has changed in terms of prognosis, but now the family feels they are not alone and have support.

By being honest, clear, comforting, and supportive, the doctors gave this patient and family a great gift. And as you perceptively realized, they received a gift as well: instead of feeling that they had "failed" the patient and family, amidst the sadness, they could feel comforted by the knowledge that, at a crucial life moment, they gave the family understanding and support. Although they face a very

distressing future, the family is better equipped to face it because of the trust and connection they have developed with these skillful physicians.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

The past couple weeks spent in the Emergency Department have exposed me to many heartbreaking, critical clinical situations, particularly in the trauma bay. What has struck me the most is the scene that unfolds when patients arrive pulseless. I had a few peripheral experiences surrounding situations like this while on my other rotations, but the seemingly back-to-back traumas I've witnessed in the ED have affected me much more profoundly.

When patients from the field are expected in the ED, the coordinated preparation amongst the staff and accompanying silent suspense are striking. The patient is wheeled in, sometimes already undergoing compressions by a machine thrusting, perfectly timed, into their chest. They are transferred to the trauma bay bed and suddenly all hands are on deck to give manual chest compressions, administer epinephrine, perform emergency thoracotomies, intubate, put in central lines and chest tubes, perform a FAST ultrasound, assess traumatic injuries, etc. The coordinated orchestration and teamwork is surprisingly hectic and imperfect, and everyone is analyzing the situation, listening for cues and favors.

In the worst cases, I'm sure many are wondering, in the backs of their minds, how many rounds of CPR will be performed, or when a discussion will start about when it's okay to stop working in the hopes the patient's heart will start beating again. For the patient with a bullet wound through the back of their skull, or the one subjected to an auto-vs-peds hit and run who is losing more blood than can be transfused, or the biker that was thrown 20 ft off of his motorcycle on the freeway, the decision to stop our efforts doesn't appear to ever get easier. I respect that the trauma surgeons and ED attendings, no matter how dire the clinical situation appears, always start the trauma activation the same way. There is always hope that the patient will respond to resuscitation, and the effort that everyone in the room puts in is always 100%.

In all of these scenarios, I have felt absolute sadness for the patient and their family/friends, but I've also felt a sense of pride that the responders to the incident do everything in their power to save the patient. When risks and futility start to outweigh benefits of resuscitation and the decision is made to halt their efforts, in the same way everyone banded together at the start, they unanimously stop. It's even more evident to me now that not every life can be saved, but the wholehearted effort by the medical team to give each and every patient a chance is inspiring.

COMMENTS: --, I appreciated both that you saw the hectic, imperfect nature of the ED, as well as its "coordinated preparation" and "wholehearted effort." To me, this sums up the reality that in this setting, as in all healthcare settings, people are fallible humans trying their best to do the right thing. Once we can accept this, it can make us admire and respect that effort even more.

I think related to this is your mixed feelings, which I've experienced as well, in the presence of great tragedy and great effort to mitigate that tragedy. The tragedy makes us feel sorrow and grief; yet the fact that people are working together to prevent that tragedy can make us feel uplifted and proud of the human race. It's a strange experience, because both feelings can be true simultaneously.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I completed my clinical observation assignment during interview season. I chose to shadow my father, a pediatrician, on rounds at LA County/USC Medical Center in downtown Los Angeles. My father completed his residency at this hospital and has remained a volunteer attending for over 30 years. On Thursday morning, we arrived together at 7am for "Problem Rounds." This case-conference presents a challenging patient case where an audience of medical students, residents, fellows, and attending physicians attempt to diagnose a unique patient case. This particular case was of an otherwise healthy 17 year-old male who experienced a cardiac arrest during wrestling practice. Prior to this incident, the patient was experiencing several months of chest pain that was relieved while lying down. The differential included several likely suspects – pericarditis, drug use, and hypertrophic cardiomyopathy. Ultimately, the patient was diagnosed with anomalous coronary vascular arteries, which were surgically corrected. It was great to see how the case was dissected and analyzed, especially with the expertise of the cardiology and cardiothoracic specialists. It was a powerful reminder of the collaborative effort of medicine.

After problem rounds, I shadowed my father and a team of pediatricians on rounds. It was especially fun for me to see how my dad interacted with the residents and medical students. He asked tough questions, but was thoughtful and encouraging. I witnessed how my dad carefully helped the team arrive at a reasonable plan. Thankfully, my dad didn't put me on the spot! However, it was still a powerful experience to observe the interactions without having to actively participate in patient care or worry about being evaluated. When I'm on rounds at UCI, it's easy to feel intimidated while presenting a patient case. This experience reminded me that, while it can be nerve-wracking, the attending is just another person listening and trying to help you learn. Working with my dad reminded me of the kind of doctor I hope to be – engaging, knowledgeable, enthusiastic about teaching, kind, and compassionate. I'm excited that we get to share this amazing, yet challenging, profession together!

COMMENTS: --, you are right, it is a beautiful thing to see when a bunch of very smart people assemble to work together for the good of another. It is the epitome of teamwork that captures the why of collaborative efforts.

It seems fascinating to shadow a physician who also happens to be your father. I wonder how the fact of his being your parent influenced - if at all - the way you viewed him. Did you notice som of his "father" traits emerge in his interactions with residents and medical students? Or vice-versa? Did knowing he was your dad help you see him as a person as well as an attending? Did you feel protective of him? Proud? He sounds like an amazing attending and a wonderful role model :-). You are indeed fortunate that you will be sharing the work of medicine with someone you clearly love and admire so much.

Your conclusion is a wonderful taleaway from this experience. Yes indeed attendings and residents can seem very intimidating to those lower down on the food chain. Being willing to show your humanity (even if you are not their parent) will help put your future learners at ease and make the

learning process more enjoyable and more effective (people learn better when they're not scared to death :-)).

Art of Doctoring 2019-20 Clinical Observation

One of the most memorable physician encounters I experienced was during my OB/Gyn rotation. On a service that was constantly busy, I worked with an intern who on her very first day took ownership of her patients and made sure that the team ran as smooth as possible. One particular instance was a patient who we were STAT paged to the bedside to evaluate for bleeding. Although the patient was rightfully worried, the intern stepped into the room and commanded a sense of calm confidence. She was able to assess the situation within seconds. She turned her head towards me and gave me a look that signaled that she herself felt unsure of how to proceed and would need to call for help. Despite this uncertainty, she addressed the patient and her husband's questions in a very compassionate and kind manner. I had never seen a physician so eloquently convey kindness in such a stressful moment.

This moment stands out to me out of all my encounters during my clinical rotations because I strive to become a physician like her. I know there will be moments in the future where I will find myself stuck in a hole, and must continue to exude confidence to my patients. But it truly takes an act of empathy to understand what the patient must be going through and to be that beacon of support to help them get through it.

COMMENTS: Thank you for this observation, --. It raises a really interesting and important aspect of clinical care. Every physician from new intern to experienced clinician will encounter a situation where they are unsure and need to "ask for help." In such circumstances, it is easy to feel anxious, and to convey this anxiety to the patient (which of course the patient doesn't need).

In the case of your intern, I think she discovered the key ingredient, which is being aware of and comfortable with your limits. When you try to "fake it," pretending you know everything, your own disingenuousness will leak through to the patient, who will sense something is wrong. When you accept your own limitations, and know how to remedy them, you will be truly calm and able to support the patient in a kind and compassionate manner, which is exactly what is needed.

So for me, the interesting question becomes: what is the nature of the intern's confidence? I suspect it was rooted in both humility and a clearsighted grasp of her overall ability, so that acknowledging a limitation in this situation did not undermine her sense of herself as a competent, capable physician. When you are able to find this balance, you are secure in yourself as not superhuman but able, and can behave in a truly patient-centered manner.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

An interaction which has reverberated with me for over 12 months now was on clinical wards during my internal medicine rotation. A patient mentioned to a nurse that she has not seen her attending physician in over three days. The team, including myself, were immediately puzzled when this was brought up during our table rounds as I precisely recall the attending visiting this patient every day. What surprised me the most in this situation was the degree of distraught the attending had. Immediately after our table rounding had ended, the attending insisted on rounding on that patient first. Although he seemed disheartened, surprised and distraught with the team, as he entered the room, he expressed confidence, enthusiasm and excitement to be visiting our patient. As the patient's interaction wrapped up, his method of addressing her complaint was subtle, he apologized if he had ever been abrupt in their interactions and asked, "have we been able to satisfactory answer all your questions in the past few days?" She enthusiastically responded in the affirmative.

In this interaction, I noticed our experienced attending set aside his own emotions and place the patient's concern at the forefront. At no point did the attending confront the patient regarding her complaint, and his rational has directed my interactions with my own patients. I later asked why he had not directly inquired for the motives of her complaint and his response was simple and elegant when he responded "it would not change my management." I understood at that moment that the interactions we have with patients are complex and at times we must be comfortable with being uncomfortable not knowing everything.

COMMENTS: --, this is a really interesting encounter. I'm not sure I understand fully what happened, but it sounded as though, unless the patient was confused, she was using the phrase "had not seen her attending" as a stand-in for saying she did not feel "seen" or paid attention to. When the attending heard this feedback, personally he was hurt and upset, presumably because he thought he'd been doing a good job with this patient. He then prioritized addressing the situation, returning immediately to the bedside and being fully engaged and present (which I deduce from your description of his "confidence, enthusiasm, and excitement"). He apologized for any abruptness in his manner previously, and checked with the patient to ensure her needs were met by this visit.

What I think was commendable about the attending's behavior is that he did not take the patient literally - i.e., he did not argue with her over whether he'd actually rounded on her or not. Instead he recognized that the patient felt neglected and uninformed and set out to remedy the situation. He apologized for his previous demeanor and asked the patient directly if her concerns had been addressed.

One lesson (among many) here is that our motives are important (I'm sure the attending thought he'd been an attentive physician to this patient), but how we come across to others is the most important. The attending's apology did not necessarily agree with the patient's perception, but it acknowledged that he hadn't been successful in conveying attention and caring. I'm sure the attending's actions were reassuring to the patient, who now could feel that she had truly "seen" her attending and he had "seen" her.

Clinical Observation
AoD 2019-20

Rounding on a number of different surgical services has taught me a number of different ways that physicians can deal with patients. Some surgeons rush rounds while others take their time. There are clearly pros and cons to each approach, however, I prefer taking my time and really connecting with the patient and their family members rather than rushing through rounds to get to the OR. I have also noticed that some surgeons will always come back and round on their patients in the afternoon or evening, and I have noticed that these PM rounds usually are much more relaxed and meaningful for the patients, who rarely see their surgeons and may sometimes feel isolated due to the rarity of their surgeon encounters. I have decided that in my own practice, in the future, I will try to maximize the amount of time I spend with each of my patients both in the morning and evenings, in order to create a sense of connection and continuity between my patients and myself.

Although there are always many things that are competing for a physician's time, the essence of medicine revolves around being there for the patient and taking care of the patients physical and emotional needs. I have also noticed that some patients and their family members have entirely different responses to the surgeon during rounds. Some are demanding, others are respectful and appreciative, and yet others are frustrated that they are not having their needs met as quickly and as readily as they would like. I have noticed a number of different ways in which a surgeon handles each of these various patient encounters. I believe that keeping an even keel and being very grounded and balanced in your approach with patients yields the best outcomes, and I think that trying to fight or argue with a patient never ends well.

I hope to utilize a hybrid of the various approaches I have witnessed in my own future practice, and hope that the patients needs are always met. Even if it means rounding in the evening after a long and busy day, that simple act of showing the patient and their family how much you care changes their perspective of their entire healthcare experience.

COMMENTS: --, I'm glad you chose to write about different surgeons' approaches to rounds and the doctor-patient relationship. Your perceptive observations show that surgeons are not all cut from the same cloth; and that even in this highly technical specialty, there is plenty of room for human connection.

Your point about a.m. vs. p.m. rounds was quite interesting, and one I had not considered previously. But it certainly makes sense that the patient will be more alert and interactive if they are not roused from sleep by an early morning rounds.

Your point about patients' relative lack of interaction with their surgeons is also excellent, and quite true in my personal experience. I hope you will find time for twice a day rounds; but even more important I think is your commitment to pursuing connection with your patients, which regardless of the frequency of your visits, will manifest when you do see them.

You are also wise to prepare for a variety of reactions from patients and families. Of course, as you know, patients and their families are under a great deal of stress, often frightened, confused, disoriented, in pain etc. This does not excuse poor behavior, but it does encourage their doctors not to take demanding or frustrated personally, but see it as an expresson of their underlying distress. I agree

that if you can maintain a caring, compassionate attitude in the face of perceived "attacks," it is easier to reassure the patient and get the situation back on the rails. Most of the time all patients and families want is to feel that their doctor cares about them and is trying their best to help.

It sounds to me that you are going to make an outstanding, empathic, and kind surgeon whom patients will trust and respect!

Clinical Observation Writing Assignment - Due January 24th
Prompt: Brief observations of medical team/physician interactions w/ patient in hospital or clinic; with a physician of your choosing -- what you saw, heard, felt, and learned that will make you a better doctor.

During my sub-I on neurosurgery this past summer, I watched one of my mentors during a family meeting with a patient. Unfortunately, the patient was comatose and not going to make it. I wasn't sure how he would break the news to the family. At first, he gathered the family around and gave them an update on what happened, the sorts of injuries the patient had, and the statistics on recovery given the sort of injury the patient sustained. Then, he gave the family his clinical opinion on what sort of recovery the patient would have. He effectively said that the patient will most likely not make any sort of meaningful recovery, and asked them if they had any questions about that statement.

I was expecting the family to have a lot of questions, but they didn't have any. They simply said that they knew this was inevitable and they thanked my mentor for what he had done. He then gave them the options we had moving forward. The family opted to keep the patient on life support and not withdraw care. They were grateful yet grieving. It was a sad experience to be a part of, but I had a lot of respect for the family and for my mentor to be able to present such devastating information in a palatable manner.

I know that breaking bad news is a part of my profession in the future, and I can only hope to break it in a manner that is digestible by the family. I hope to learn more from other mentors and watch how they have worked to perfect the art of breaking bad news. I think that breaking news in a step by step fashion is better than just blurting out the bad news. Making sure the family understands the circumstances and is ready to hear the truth is important.

I hope that very few people will ever have to go through similar experiences, but the reality in medicine is that deaths occur all too often. I hope that with time and innovation, avoidable deaths can decrease in frequency, but I hope that the same tasteful thought can be put into the discussions with families when things go wrong as that used by my mentor.

I like what you say -- about breaking bad news in a way that is "digestible" by the family. That shows a lot of sensitivity to the enormity of what you're asking the family members to absorb. Having a structure and a plan (tempered by compassion) is a good way to go. For example, a warning shot prepares the family, and space to let them process and ask questions also helps. Finally, being aware of the emotional extent of the blow will help them begin the long journey of coming to terms with their loss.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

This was a clinical observation that I had during my medicine inpatient rotation. A patient was admitted to the hospital for anemia of unclear etiology. Patient's past care was at a different hospital, but workup of anemia, including invasive procedures such as EGD, bone marrow biopsy, and colonoscopy, were all negative and a source of bleeding was never identified. The patient's daughter is heavily involved in her care. Her daughter has always been with her at all of her past hospitalizations for anemia that required blood transfusions. On the first day of the patient's admission, the team was already aware that the daughter wants to know everything about the patient care 24/7. Although this should be a goal, it is definitely hard as the team has to deal with other patients as well. On day 3, the team, along with GI who was consulted, recommended doing a repeat EGD.

However, the patient's daughter was not made aware of that decision until the day of the procedure. Naturally, with everything that was going on in her daughter's life and the stress of her mother's condition, the patient's daughter was furious and had a break down. It also didn't help the situation that on that day, the patient was non-compliant with her CPAP and was altered mentally due to her respiratory acidosis. She proceeded to yell at the nursing staff and the medical team, accusing all of us of subpar patient care and not knowing what to do.

After this scenario, the medical team, especially the senior, did a great job at de-escalating the situation. He voiced his understanding of the daughter's concern and made sure to logically tell the daughter of what is happening and what the next steps are for treating the patient. He politely stated that he would have loved to update her, but sometimes things get overlooked because there are many other patients that require acute care as well on the service. Never once did he put the blame on other healthcare providers, nor did he accuse the daughter of saying anything incorrect. He continued to reassure her that everyone will be working as a team, along with the GI doctors, to provide the best care possible for her mother. Shortly after that conversation, the situation simmered down and the daughter was in better spirits.

COMMENTS: --, I like the way you noticed and highlighted de-escalation. Better to avoid escalation in the first place, but sometimes as you saw that isn't possible. Then the goal becomes to calm the situation, so people can make more thoughtful decisions.

It sounds as though this attending threaded the needle wellbetween not throwing his colleagues under the bus and not blaming the family member either for losing control. Mostly, people want to be heard and feel their needs and wishes are respected. Once the attending included the daughter in what was going on with her mom, she seemed to settle down and things were back on track.

Thinking to the future, and trying to anticipate (and avoid) such confrontations, with a patient who was sometimes confused and a daughter who was heavily involved with her care and expressly stated a desire to be present for all procedures, this was something that could have been handled with a bit more forethought. For example, if it is not realistic for daughter to always be present, then the team could give her a heads up - "We hear how important this is to you and we will make every effort to wait until you're able to be present. But there might be times when we've tried to contact you, or you can't come in, where it's in your mom's interest to proceed. How do you feel about that?"

This is both about reassuring the mom by having her daughter by her side; and also about showing her mom, herself, and maybe the team that she is indeed a good daughter, devoted to her mom. If the team can address this underlying need, then daughter may not feel quite so compelled to be present for every procedure.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I recently had a pretty hard case on my final MFM sub-I on an away at Cedars. We had a woman come in for decreased fetal movement and by the time we put an ultrasound on her she reported 48 hours of feeling no movement despite having a completely normal pregnancy. The heartrate upon evaluation was bradycardic at 100 bpm. C section was further delayed before it was eventually discovered the fetus had a heart rate of 40 bpm. Emergency C section was immediately performed. Unfortunately, the baby did not survive the emergency c-section. Naturally, the mother and father were devastated. However, it was from this event that I learned so much from the residents and attending's I was working with.

Although the residents and attendings were also having a tough time after such a difficult case they made every attempt to provide the mother who had just lost her child with everything she needed. I watched as they gave her enough space to grieve a difficult loss, but also made her aware that they were very much there for her if there was anything she needed. It was from this moment that I watched their passion for their specialty coincide for their passion for human life. I learned from these doctors that sometimes it is okay to be vulnerable. At the end of the day, feeling some emotion and caring for your patients makes you a better doctor. Even though we will deal with difficult outcomes, that compassion and caring for a patient makes us better doctors.

COMMENTS: --, you have a beautiful line in this essay: "It was from that moment that I watched their passion for their specialty coincide with their passion for human life." This was a profound observation that shows you understood at a deep level what was happening in this tragic case: these doctors were deeply committed to MFM and just as deeply committed to supporting the human lives unfolding before them.

I agree with you absolutely that "feeling some emotion and caring for your patients makes you a better doctor." From my perspective, the key is learning not to be overwhelmed by your feelings. It's important to feel something for your patients, to know what you are feeling, and then help put that feeling toward supporting the patient. When we become lost in our own emotions, we have accidentally put ourselves at the center of things. When we can understand our feelings to create compassion and empathy for the patient, then we have put the patient back at the center, where they belong. This process is exactly what you witnessed and appreciated; like you I believe not being afraid of emotion, but recognizing it as part of what makes us human, will also make doctors better at what they do, and will actually help them avoid burn-out.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

I was recently part of a series of two family meetings for a young female patient with a rare mixed mediastinal tumor admitted to the Medical UCI with acute hypoxemic respiratory failure secondary to tumor burden and obstructive pneumonia. When I first encountered the patient, she was intubated and lightly sedated, and her Korean-speaking mother was at bedside. The mother spoke little English and asked a few questions about her daughter's lung and breathing tube, thus we brought in the MICU team to help explain her daughter's current condition. We brought the mother to a separate room as the patient was still conscious and able to follow commands, and with the help of an iPad interpreter, the MICU team shared with the mother that her daughter had a rare and very aggressive cancer that was untreatable.

Unbeknownst to all members of the care team, this was the very first time the mother was informed of this diagnosis, as the patient had been seen by multiple specialists at different hospitals, and because the patient was discharged from UCI one week ago following a spinal decompression surgery, the mother thought the cancer was cured. The mother completely broke down, crying and screaming and clutching her heart with grief, and unfortunately, she was alone; her husband was on his way to the hospital and would arrive two hours later.

We had a second family meeting when the patient's father arrived. With a better understanding of what the family already knew and what they hoped to accomplish with the hospital stay, the MICU attending was able to better explain to the family the patient's current condition. There was still a gap in understanding with just verbal communication, and visual depictions via radiographic imaging was much more helpful in conveying the information. Although the parents did become tearful, the meeting felt more productive, and the family was able to convey their hopes while understanding the gravity of their daughter's terminal illness. She was diagnosed over a year ago, and this was probably the first time anyone had ever fully explained the daughter's medical condition to the family.

This was a very difficult encounter to participate in, but I learned many valuable things. First, the significance of a language barrier. I wonder how much information was missed by the family because of the language barrier, and whether the patient would have sought more appropriate and intensive care sooner, had her family spoken English. Also, in our initial encounter with the mother, had we better understood her questions and expectations, we would have approached the initial meeting much more tactfully, and probably not have had it at all until the husband had arrived. Second, in such family meetings, it is best to start by assessing what the patient and/or family already knows, and by asking what questions or topics are most important to the family, before sharing information from our end. Doctors are smart and good at talking and sharing information with their patients, however we still struggle to listen.

COMMENTS: --, you make many valuable points in your assessment of this painful encounter. First and foremost is your observation that it always makes sense to find out what the family knows. Then, as you say, you can calibrate the conversation to their level of existing knowledge. Your conclusion is very wise - doctors are good at talking, but could improve on listening.

The second point has to do with the complex interplay of language/culture, denial, and poor communication on the part of physicians. As you note, much gets lost in translation, so working across language requires meticulous attention that the message is indeed received. Also, of course, many cultures have constraints around death and talking about death, so if possible it's important to figure those out in advance. In addition, no one wants to hear this kind of news, and our minds instinctively throw up barriers, so again, with compassion and care, we need to assess that the family grasps what's been said. Saying it is not enough. Finally, I suspect that if you asked the doctors who'd been caring for this patient whether they'd conveyed the gravity of her situation to the family, they would all say yes. These are very hard situations to deal with; and it's incumbent on the doctor not only to think they did a good job, but to verify that in fact they've succeeded in getting across the difficult information in a way that the family hears.

You also had an excellent insight about perceived urgency. Of course, in many situations, it's essential to break bad news as quickly as possible to the family. But in this case, the mom had gone a year not understanding the seriousness of her daughter's diagnosis. Waiting until she had the support of her husband would have been more humane, by possibly heading off a traumatic exchange. Nothing was really gained by the initial interaction, which had to be repeated in any case. Sometimes our need to "do something" overrides the better course of pausing and thinking through what is the best way to proceed.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION Write a couple of paragraphs on your observations of a medical team/physician's interactions with a patient in the hospital or clinic. What did you see, hear, feel, or learn that will make you a better doctor?When I was on my cardiology rotation, I saw a powerful interaction between a patient, her family and the attending physician. The patient was in her 80s, and had heart failure, kidney failure and numerous other comorbidities. The patient had been seen by the attending for many years and they had a good relationship. During this clinic visit, the attending told the patient that her heart failure was becoming difficult to control in the setting of worsening kidney failure. He explained to both the patient and her daughter that the only option was to aggressively treat the heart failure with diuretics with the understanding that the dehydration would likely worsen her kidney function. He then brought up to the patient and her family that in cases such as hers, it would be appropriate to bring the palliative team in to discuss the patient's goals of care. The patient mentioned that she would be traveling to Hawaii and the attending offered to do weekly phone visits with the patient to make sure that she was meeting her weight and fluid goals while out of state.

I thought this interaction was an example of a good doctor-patient relationship. The attending was understanding and kind, but also very realistic with the patient and her family. He told them directly that her prognosis was not good, and it was time to bring in the palliative team to discuss the patient's goals of care. I also appreciated his willingness to go the extra mile for the patient by offering to check in with her every week while she was on vacation. This interaction made me think more deeply about the many challenges of treating patients with chronic conditions. In this case, there was no ideal outcome because controlling the heart failure would lead to worsening of the patient's kidneys. However, I did learn that being compassionate and forthcoming with a patient in a difficult situation can greatly improve the relationship between patient and physician. I want to incorporate what I learned from this encounter into my future practice. I want to be the doctor, who is willing to make an extra phone call for 5 minutes every week to check in on a patient. I want to be the doctor, who is trusted by a patient's family and can make the difficult decision to start a goals of care discussion.

COMMENTS: --, like you, I'm pretty impressed that this doctor was willing to call his patient weekly to monitor her condition. That's rare! I agree with your analysis completely. Compassion and kindness do not mean beating around the bush or being vague about conveying difficult information. The role model you chose seemed to find the perfect balance of honesty and caring. As did you, I liked the fact that the doctor initiated the idea of the palliative team's involvement. Patients and family members may both understand and resist a difficult prognosis. They may not be sure "what to do next." In these circumstances, they cannot take a constructive lead, so it is up to the physician to suggest moving to a different model. This physician's obvious concern and caring for his patient will make it easier for patient and family to make this move and begin the goals of care conversation.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

We had a young woman just diagnosed with pemphigus vulgaris. The condition had progressed rapidly—just one week ago she walked into an urgent care clinic in Riverside to check out some "weird skin patches." Now, she was lying immobilized in a hospital bed with her skin sloughing off in sheets, barely held together by rolls upon rolls of bandages and gauze. She had just been transferred from the burn unit and so was new to our medicine team. During rounds, we shuffled into her small room filled with bouquets and well wishes from her friends and family. In contrast to the joyfulness of the room, however, our patient was clearly anything but. Her face settled into a scowl as another crowd of white coats entered. My attending astutely recognizes this and immediately goes to sit at the edge of her bed, eye level with her. After asking gently what was wrong, our patient explained her frustrations with not knowing exactly what was going on with her condition, feeling like she's been tossed around from specialist to specialist. Her eyes filled with tears as she confessed how scared she was, and if she'll ever be "normal" again. In response, my attending fully acknowledged her concerns and firmly reassured her that our team would be here for her every step of the way, and to do our best in informing her of every medical decision. Over the days, we developed strong rapport and trust with her. By the end of my rotation she would always smile when we would come into the room. Although we couldn't do much in the way of actually treating her condition, I observed the way that true compassion and empathy were integral components of treating a patient holistically. I hope to incorporate what I learned from this experience into my everyday practice as a healer.

COMMENTS: Dear --, both you and your attending were superb observers - the attending of the mood of the patient, and you of the attending's sensitivity. Sometimes we overlook other people's negative emotions, but a lot of times it makes more sense to notice the elephant in the room. If you're able to ask, "What's going on?" it signals you're not afraid to be with the patient's anger or upsetness or whatever; rather you're here to help them get through it.

Sitting at bedside is a wonderful technique, although I think it is a good idea to ask permission. Most patients feel very comforted by this gesture; but I've seen a few patients who bristle, because they regard their bed as their "territory," the one small space over which they have a modicum of control.

This attending clearly had a trust-building, empathetic demeanor, and knew how to create a sense of safety for this patient, who was able to confess her fears (and it's worth remembering that beneath anger is usually fear).

As you saw, by expressing sincere concern for what the patient was going through, this attending won her trust, with a resultant shift in mood. Although the team could not do a great deal for her, the actions of the attending made her feel that people cared about her, that she was not alone, and that everyone wanted to give her whatever support and care they could. Having this context is actually a huge help to patients in allowing them to concentrate on their healing.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

One of my most meaningful and emotionally charged encounters were in the ICU. One encounter specifically was with a 28-year-old patient who was in a motorcycling accident. He had only broken his femur, but after the surgery to reset the bone, he had fat embolize to his brain, and was left in a state of minimal consciousness. Because of the dreadful complication, the family was understandably upset, as he had come into the ER talking, and less than 48 hours later he was essentially in a comatose state. Unfortunately, this is a known complication of orthopedic surgeries, with currently little that medical professionals can do to prevent from occurring. For the next two weeks that I was on my ICU rotation, I acted as the family's updater, and was also able to observe how the residents and attendings respectfully and gracefully explained the options available. During one of our meetings with the family and the Palliative team, I was especially moved because we spent about 10 minutes of our 40-minute meeting just talking about the person that he was. The family talked about his career in the military, what position he played in football when he was in high school, and about his budding music career. They even played one of his songs on Spotify. I found this cathartic experience necessary to provide closure for the family that they had done their best to ensure that the medical team of their son/brother/uncle had an appropriate understanding of the individual they were caring for. Forming that personal connection with the family helped to establish trust, which although did not make future decision making easier, they were more achievable when both parties felt they were on the same page and had full understanding of the patient's best interest. I know that those 10 minutes made a lifetime of a difference for that family, and the significance of that memory will definitely follow me in my future patient encounters.

COMMENTS: --, this is truly a tragic tale. Nothing "redeems" the loss of the person that this young man was. Nevertheless, I have great respect for the way the Palliative team created space for the family to share the personhood of this patient - who he was, and what he meant to them. Imagining their playing one of his songs was deeply moving to me. You understand very well that the family needed the medical team to see their loved one not just as someone in a comatose state but as a wonderful human being. This exchange might not make future decisions easier, but it creates a sense of trust and connection between team and parents, and THIS will be invaluable down the road. Knowing you, I'm confident you will indeed remember these 10 minutes, and how significant they were to both family and team.

ART OF DOCTORING 2019-20 CLINICAL OBSERVATION

"How's the game going?" The attending asked her patient who was lying in bed. She had explained to us before going into the room that, "it's important to first make a connection with your patient that is not related to medicine." "It's good." The patient responded not taking the bate.

"You enjoy the meal?" The attending said, picking up the empty plate of food?

The patient shrugged.

"Well Mr. Doe, I understand you came in with HPI and are now Subjective. The plan moving forward is plan."

The patient nodded his head, looked at his daughter who sat there with the same blank stare that said, I'm supposed to understand this but I don't so I'll just pretend I do by remaining silent. We walked out of the patient's room.

"So." The attending said, turning to the nearest MS3 with confidence, "What do you think I did right in there?" Poor MS3 caught in the headlights. It's bad enough trying to maintain attention while your attending fumbles through rapport building, but to be asked to give a compliment on how they did is just cruel. Not that I blame the attending, not every patient interaction is warm and fuzzy no matter what algorithm you follow.

"Umm, I really liked how you brought up the baseball game."

The attending smiled, "Yes! Did you see how just with that simple statement, I had gained his trust?"I

n my mind, I rolled my eyes and vomited at the same time. I imagine if you examined my face at that moment, you'd see my eyes widen just slightly and lips tighten to prevent myself from smirking like the smart ass I am. "--?" The attending turned to me. I felt my stomach drop to the floor. "What do you think I could have done better?"

Don't do it.

Don't even think about it. It's a trap! "Well . . . I don't know. I- I'm not sure the patient fully understood the plan"

"Why do you think that?"

You f*@#ed up --!

"Well, he didn't seem all that interactive with the conversation. He kinda just sat there and stared."

"Hmm" The attending grunted, mouth firm, slowly nodding her head. Her eyes lids lowered just the slightest. My big mouth . . .

I imagine a lot of medical students have had similar experiences. The first lesson is never criticize your boss, even if they ask. The more important lesson though was what NOT to do when educating patients. Eventually in medical school I had the fortune of working with an attending who taught me that the burden of understanding is on the teacher, and that you have to force a patient to summarize what you're telling them if you want to be sure they get it. I appreciated that lesson because by that

point I'd seen again and again patients nod their heads at attendings but not feel comfortable to actually ask what's going on.

COMMENTS: Hi --, first, I REALLY enjoyed the format you chose for writing this essay. Reading this engaging and at times humorous short story was \ **a welcome break from more conventional narratives :-).**

Second, as to substance of establishing rapport: Establishing rapport depends on meeting the patient where THEY are, not where YOU are. Maybe the patient was interested in the game, maybe not. Maybe they wanted to talk about the food, and maybe they didn't. Often, hospitalized patients have weighty matters on their minds, and this is what they want to discuss. Sometimes, it's true, they like distraction, but I suspect that the mistake this well-intended attending made was in not taking her cue from her patient.

Third, attendings asking for feedback: In principle, this is a terrific idea, and I admire any attending who woulc even give it a try. But there's a difference between asking for praise and asking for constructive feedback. For the latter to be effective, you really have to be sure you are ready to hear you don't walk on water. Sometimes, to make a learner feel safe (and in a short time, you're going to be the one asking medical students for feedback :-)), you can disclose a portion of the interaction you were uncertain about, and let them know you didn't think it went particularly well. This gives permission for a more thoughtful critique.

For what it's worth, I don't think you were an idiot for taking the attending at her word, and trying to point out a deficit in the interaction with the patient. Maybe she wasn't quite ready to hear it, but the culture of medicine will never change unless we begin to alter the way we interact with each other; and an important place to begin is with honest assessment of our strengths and weaknesses. That's how we learn, all of us!

Fourth, doctors teaching patients: Your second attending was very wise - "the burden of understanding is on the teacher." An eloquent and organized presentation of the plan is useless if it isn't received on the other end. And ensuring that this happens is the responsibility of the physician. Similarly, it is up to the doctor to figure out, if possible, how to connect with their patients. These efforts don't always succeed, but often even in apparently difficult circumstances, if you make an effort, a path forward opens up. Regardless, you will feel better for having tried, and this in itself will give you an easier interaction with that patient.