Comment #1
I can understand your reaction. It is hard to think of this man wanting to “move on” from a longstanding marriage. On the other hand, it shows great trust in the nonjudgmentalness of the physician that the patient would risk raising this issue.
Comment #2
I appreciate your humility on this point. Caring for a person with AD is incredibly difficult and demanding. Often patients are aggressive and combative, and require unremitting attention and care that can be beyond even the most devoted caregiver.
Comment#3
Yes, it is easy to stereotype older persons as “not interested” in love, but in fact love can come to someone at any age.
Comment #4

Very well said, and I agree.

Comment #5

This is easier said than done for most of us; but by developing consciousness of how our implicit biases and assumptions might operate, we are more likely to avoid falling into them!

COMMENT #1

This is a really well-written description of what goes on in the mind of a medical student confronted with an unenthusiastic patient. Funny and also insightful. I also respected all the different approaches you tried to win her over. Something you might add to your arsenal is simply to ask the patient, "You seem uncomfortable. Can you help me understand what's going on?" Or "Is there anything I can do to make you more comfortable?"

Comment #2

These speculations are a good reminder that the patient's attitude may have nothing to do with you. This is why it's always good to ask directly when "something is not right."

COMMENT #3

This is true - the medical student role has been described as a "liminal" one, neither twixt nor tween.

Comment #4

You will certainly soon tip over onto the side of knowledge, if you haven't done so already. However, it is rarely lack of knowledge in the physician that makes the patient uncomfortable, but rather some interpersonal difficulty that will need to be addressed for things to proceed smoothly.

Comment #5

Adam, you did a superb job of recreating your own doubts and anxieties, as well as those of the patient and your futile efforts to overcome them. I think when we feel that tension or lack of connection in the room, it can help to simply surface the problem. Let the patient know you and she can talk openly about any problems - in her health, or in your relationship. As you pointed out, her demeanor could have nothing whatsoever to do with you. Or you could have inadvertently offended her in some way. By simply asking whether there's anything upsetting her, or how you can put her more at ease, you can address the difficulty directly.

Comment #1

Based on your description, I'd agree, the patient does seem to have an "agenda," which is to get your attending to refill his tramadol prescription. This is where it gets interesting. How are you going to deal with this agenda?

Comment #2

Oh, oops. Great minds....

Comment #3

This is a profound statement. I'd suggest that perhaps the patient IS in pain, perhaps "physical" related to his back; but almost certainly psychological related to his dependence/addiction. So the question becomes, what kind of "pain alleviation" does this patient need?

Comment #4

A crucial question to ask given the epidemic of opioid addiction that we have in this country, created at least in part by physicians' well-meaning but naïve overprescribing of opioids.

Comment #5

Johanna Shapiro: You are framing the question very well. And sometimes it is a good course to be transparent - share your thinking with your patient. Let him see the dilemma from your point of view.

Comment #6

This is not a good sign - it suggests the patient is very committed to ongoing tramadol use.

Comment #7

Agree. When addiction is driving the narrative, doctor-patient relationship takes a backseat... FOR THE PATIENT WITH ADDICTION. However, the doctor does not have to respond in kind. You can still prioritize your commitment and care for the patient, and this is what should guide your response. In these situations, it is important not to take the patient's manipulation personally. Patients who are addicted to drugs, and suffering because of it, will do what they can to get those drugs. You should

not give in to manipulation, but you don't have to become offended by it either. At the same time, you can be transparent about this process as well, and let the patient know that you know what he's doing.

comment #8

Absolutely, boundaries are definitely part of the doctor-patient relationship. By not overprescribing opioids, you are acting in the patient's best interest, even though the patient will likely not thank you!

Comment #1

Excellent - that's how we want it :-)

Comment #2

Redirecting was a good initial strategy. In this case, it didn't work, but it was a good place to start. I wonder if you discussed this situation with your preceptor. It is difficult for you to set a limit with this patient because this is not your practice, but especially since this was a longstanding problem, the preceptor needed to discuss it directly with the patient. You could push back indirectly, re "hippo" statement: "I'm surprised to hear you make a comment like that"; with the "finest girl" statement: "The MA who will be doing the injection is extremely competent and skillful." In the first instance, this challenges the patient's verbal behavior; and in the second, models a more appropriate way to refer to staff.

Comment #3

I think you made an excellent start in an uncomfortable and inappropriate situation. The line that interested me the most was "The patient has been known to make inappropriate comments to the women of the clinic..." If this behavior had happened more than once, in my view it is really the responsibility of the physician to address it with the patient, pointing out politely but clearly that, although the patient seems to be "joking," it is disrespectful to your staff and not appropriate. The physician has an obligation to protect her/his staff (unless of course it is the staff who is behaving inappropriately). Silence implies consent.

Imagining this situation occurring in a setting in which you had continuity care and saw the patient more than once, you might have started with redirection (as you did), then moved to indirectly challenging or more appropriate modeling (as suggested in the comment). If the patient persisted, you could confront the issue directly, stating explicitly that it was not appropriate behavior and the patient would need to refrain from making such comments in the future. If you had time, it would be

valuable to explore his demeaning, sexist attitude - is he trying to "bond" with the male physician? Is his anxiety in a healthcare setting expressed as needing to show superiority over another?

Comment #1

This is a great insight! Physicians depend on patient cooperation, but often simply expect this to happen as a matter of course. Yet not every patient can or will cooperate, and it is up to the ingenuity of the physician to work around this obstacle.

Comment #2

You are quite correct, in most circumstances, open communication is dependent on trust flowing both ways.

Comment #3

Understandably so. I think one of the great challenges of becoming a good physician is learning how to cope with feelings of helplessness in constructive ways that neither contribute to physician burn-out nor lead to patient blame or judgment.

Comment #4

That is wonderful. Why do you think this happened? I suspect at least a contributing factor was your perseverance in the face of the patient's uncooperativeness.

Comment #5

How great that, after your initial frustration, you could celebrate this small but significant victory.

Comment #6

Sadly, this is not always the case, and the explanation for this reticence is not always psychiatric disorder. It's clear you learned an important lesson from this experience.

Comment #7

Alexa, I appreciated your openness to regarding this frustrating experience as an opportunity for learning, as indeed it was. It is frequently the case that patients are reluctant to tell you the "whole story," either because it is hard to formulate, they feel a sense of vulnerability, they are angry and afraid, or for some other reason. Learning to take a breath in these situations, being curious not "furious," avoiding judgment yet persistently trying to draw out the patient, or create space for the patient to disclose more freely are an important part of being a good doctor.

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comment#1

I can only imagine how difficult this first-ever pap was for a 56 yo woman from a different cultural and language background. She must have been so frightened and uncomfortable. It sounds as though you and the attending did everything right, proceeding slowly, providing detailed explanation, skipping the bimanual .

Comment #2

This is puzzling. I wonder why this happened?

Comment #3

If you had taken this approach, the mother might have been able to benefit from the daughter's presence if this is what she wished but as a support rather than a translator.

Comment #4

This is an excellent thought. I wonder how familiar the daughter was with this process, and if she felt comfortable remaining with her mother and providing explanations about a very intimate exam.

Comment #5

I appreciated your very thoughtful essay. I agree that clinical situations are more nuanced than a standardized exam question! In this case, I'm almost certain a strange phone interpreter would not have set the patient at ease either. Perhaps one of the problems was neither mom nor daughter quite understood what they were getting into. Perhaps if a bit more time had been spent preparing them for what was coming, the daughter might have been able to persevere with her crucial role. Of course, it is very hard to carve out such time - but in this case, perhaps the patient's distress could have been eased, and this has to be weighed against priorities of efficiency and productivity.

Comment #1

Ha! Nice awareness. Patient privacy is honored more in the breach than in the observance!

Comment #2

Fake it till you make it?

Comment #3

You are very honest, and I appreciate this. Without acknowledging our often less-than-noble feelings, we cannot move in the direction of optimal care.

Comment #4

In this exchange, you are trying to engage the patient in cognitive reframing, i.e., help her think about the situation in a less negative light. This can be a very useful therapeutic strategy.

Comment #5

It is interesting where our "natural" empathy arises. Empathy for the daughter of this apparently demanding, histrionic, and self-centered woman is a valuable thing. Perhaps there is some way to find empathy for the patient as well?

Comment #6

Ha, great touch! What a lovely example of parallel process.

Comment #1

I certainly understand where you're coming from; and I would feel the same way. What do you think the patient would say?

Comment #2

Very empathic statement.

Comment #3

It is very common for JW patients to be constantly surrounded by other members of the community who are there to support the patient and maintain them in their decision. On a few occasions I have heard of patients changing their minds about blood products if it is possible to clear the room!

Comment #4

So the difficulty here was not only dealing with a devout JW patient, but also with a skeptical and suspicious girlfriend, also JW, who continually challenged the physicians. Sometimes in such a case it can help to bring in a third party; for example, someone like Dr. Minh-Ha Tran, a pathologist who has worked for years winning the trust of the JW community.

Comment #5

I commend the team's patience and persistence.

Comment #6

Perhaps a small miracle, and certainly something to be grateful for.

Comment #7

I believe some, but not all, are agreeable to this. I could be wrong, but I think there is a range of what is acceptable and forbidden within the community.

Comment #8

Exactly. Whatever the logical flaws in a religion's belief system, logic notably fails in dissuading a believer from belief. My understanding is that JW adherents believe that their immortal soul will be damned if they accept blood products. This makes it more understandable why they would risk death rather than jeopardize immortal existence.

Comment #9

Sometimes science and faith find common ground, and sometimes not. Someone at UCI who has tried to bridge the gap with the JW community is the pathologist/hematologist Dr. Minh-Ha Tran, who has worked closely to build trust with the JW community. Involving someone like this can assure patient (and other JW representatives) that no stone has been left unturned to respect their religious beliefs while trying to guarantee the safety of the patient. I am very glad that in this case the patient survived.

Comment #1

This is one of the hardest situations physicians have to deal with, especially in the midst of an opioid epidemic.

Comment #2

I find it interesting that you were asked to do this. Did your attending give you any guidance in terms of how to approach this sensitive topic?

Comment #3

Good awareness of your own emotions. If you recognize your feelings, you will be better able to ensure that they don't complicate an already difficult encounter. Guilty, helpless, frustrated, overwhelmed, manipulated - these are all strong negative emotions that can make us want to get away from the situation as quickly as possible, or punish the person who is "making" us experience these feelings.

Comment #4

An encounter with a patient seeking narcotics is one of the most difficult in medicine. Whatever relationship exists may be manipulated for the purpose of trying to obtain relief. Many experienced

physicians struggle with these interactions and dread them. There is no algorithmic way to proceed, no "trick" that will guarantee success. I think it helps to keep two things in mind: 1) Your patient is suffering, and seeking to alleviate her suffering in the best way she knows how 2) You have certain legal and ethical boundaries to which you must adhere, for the good of the patient and the profession. This double awareness can help guide you with both compassion and firmness. I wonder if your attending gave you any suggestions in terms of how to handle such a difficult situation. This is where important learning from someone more experienced and skilled can occur, but only if that individual is willing to offer insight and guidance.

Comment #1

I can hear the resident's struggle to take the best possible care of this patient while also trying to honor the pt's desires and preferences. It sounds like the resident was able to negotiate a balanced treatment plan and to make referrals that the pt would find compatible with his beliefs. It sounds challenging, but very well managed.

Comment #2

Wow, this is awesome. It doesn't always happen this neatly, but kudos to the pt for implementing such dramatic changes; and kudos to the resident for supporting the pt in driving his own healthcare.

Comment #3

Excellent conclusion. I agree!

Comment #4

Yes, absolutely, good insight. Such frustration would be natural, but could lead to less than optimal care for the pt. In your account, you can see that the resident also was concerned, but was able to work with the pt to find common ground.

Comment #5

Beautifully said, Alyssa. This is exactly what was going on here.

Comment #6

Thank you for sharing such an exemplary success story. I can see that the resident initially struggled with the patient's preferences for alternative approaches, as this went counter to his medical training. However, his open-mindedness and willingness, as you observed so insightfully, to collaborate with the pt, rather than try to impose his will, led to an outcome nothing short of

miraculous in the world of diabetes/obesity/hyperlipidemia management. You extracted exactly the right lesson in my view. Physicians must first understand and respect, and then work with, pt's cultural beliefs and expectations in order to achieve meaningful outcomes. This was a wonderful illustration of how well this can work.

Comment #1

I think I understand what you're saying; if so you are making a very nuanced point, and one I agree with. The use of the word "stereotype" may be problematic because it has such negative connotations - but my interpretation is that you are arguing against throwing out all knowledge about people from a particular cultural background because it might indicate bias, while at the same arguing in favor of acknowledging and respecting individual difference. In other words, if prolonged eye contact is considered offensive among most members of a particular cultural group, that is good to know; but if a member of that cultural group actually prefers sustained eye contact, then that needs to be incorporated in care.

Comment #2

Creative idea, especially if it could be conducted in such a way that would reduce negative stereotyping and enhance cultural humility. A financial incentive seems a good motivator!

Comment #3

I LOVE this idea! So the patient would become the physician educator. I suspect having such a session would have many benefits in addition to increasing cultural competence. It is similar to current provisions for primary care physicians to be reimbursed for EOL discussions with patients.

Comment #4

Reimbursement might smooth a lot of ruffled feathers; and physicians might actually be appreciative of an opportunity to interact with their patients on a more personal level!

Comment #5

I think a good approach in medicine is based on the old Russian proverb, trust but verify. Patients can lie to physicians for many reasons - fear, embarrassment, manipulation, wishful thinking etc. Sometimes doctors "lie" to patients by obfuscating hard truths. People lie to other people,

unfortunately. In medicine, the goal is to create a doctor-patient relationship in which both patients and doctors feel safe enough to be as honest as possible.

Comment #6

Beautifully said, I am so impressed to see you go beyond the (understandable) feelings of anger, betrayal, and sadness that most students feel when they discover their patient has not been truthful. (Experienced physicians sadly often have passed beyond these emotions to cynicism and disillusionment).

Comment #7

I'm glad to see you frame heroin abuse as a "cultural" issue because without understanding the social circumstances of the patient, we can never begin to understand their situation, much less be helpful to them. Sometimes you have to hope for your patient when you patient no longer hopes for themselves, and "hope" that your hope will rekindle a spark in them. This does not mean naive hope, merely holding at the possibility that change can happen, although often it does not. Even when it does not, that patient is still deserving of care and respect.

Comment #1

This can be a very difficult determination, but from your description it seems appropriate in this case.

Comment #2

This is an excellent point! Often the difficulty the patient creates does compromise their care, which is unfair to the patient, as their difficult behavior often emanates from circumstances beyond their control, as in this case.

Comment #3

Frustration is natural and understandable under these circumstances, but it should be the starting point not the ending point in trying to creatively figure out how to give the patient the care he deserves - which in this case it seems is exactly what the team did.

Comment #4

It is wonderful when the efforts of the healthcare team are met with gratefulness and appreciation, as they often are. However, it is worth asking whether healthcare professionals have a right to "expect" gratefulness - is this a kind of unstated contract that exists between patient and doctor?

Comment #5

Excellent - and these facts are at least as important as the fact that he was rude and demanding.

Comment #6

Well said. We can never fully understand another's story. But by listening to it, we can see them a bit more clearly as you obviously did in reminding yourself of the patient's desperate circumstances.

Comment #7

Absolutely true. The first priority must be the safety of the healthcare team. As well, for patients who are seeking opioids, who have mental health issues and personality disorders etc. boundaries definitely are essential in the care. So are compassion, caring, and interest in them.

Comment #8

This essay is an authentic grappling with a very difficult and sad clinical situation. It was an excellent decision to get an ethics consult, and it seemed to provide valuable guidance. This man, beset by both serious physical and psychological disease, created a lot of frustration and resentment in the medical team because of his uncooperative and hostile attitude. This is understandable. Yet, as you point out, it is also true that this man was dying, alone and support. Was there a way to win his trust? Perhaps not, given his mental status. But I think the effort to understand him and his story is the place to start.

Comment #1

That was both a very thoughtful and very kind statement. Even if it did not help Ms. Nguyen (and we know so little of what patients in these states experience), it would certainly be healing for her family.

Comment #2

Yes, a wonderful insight; and you enabled the family to do this in culturally appropriate ways.

Comment #3

I am always wary of calling an EoL situation a "good death," but this seems like a pretty good death to me, in that the NCC made space for practices and customs that brought consolation to the family (and perhaps to the patient). I think you had the opportunity to witness a peaceful passing according to time-honored traditions. It's a wonderful example of how healing can occur even at the end of life.

Comment #1

This is such a heartwarming story! You've analyzed it very well. Because of the language barrier, some aspects of the encounter were limited and constrained by an interpreter. Yet the attending and patient had figured out a way to humanize and deepen their connection - by exchanging periodic updates about their children. This is a very touching example of how clinical medicine is constantly faced with challenges, but with a little goodwill and ingenuity human beings are often able to overcome them!

Comment #1

I'm imagining this was a really difficult encounter. Of course you were not "hurting" the patient on the initial encounter, but rather trying to determine his neurological status. Nevertheless, we can understand how the exam might have appeared to his worried mom.

Comment #2

Wonderful insight, Austin, and I so appreciate that you realize how the goal of "efficiency" ended up marring the encounter.

Comment #3

And this must have been difficult for you as well, to be dismissed by a patient and family you were tyring to help.

Comment #4

Although painful for all concerned, this encounter is a clear example of how miscommunication can arise so easily: you did not understand the mom's perspective, and the mom did not understand yours. This is where taking a little extra time to establish common ground can save much difficulty down the road.

Comment #5

Absolutely, this happens all the time; and usually in the name of "efficiency" as you noted.

Comment #6

And this is another good awareness on your part. Patients and family members who do not speak English will feel more vulnerable and uncertain, and deserve extra care in making sure they feel understood and included.

Comment #7

Thank you for sharing this embarrassing moment of being "kicked out" of the patient's room. You handled this "mistake" in exactly the right way - acknowledging it and learning from it. I especially appreciated your recognition that the driving force behind your decisions was your desire to be "efficient." Efficiency is important in medical care; but often the culture of medicine prioritizes it above all other values, often with negative consequences. Your conclusions are spot on - it is important to be aware not only of your own behavior, but how it looks to others, especially those who are not familiar with the medical system and who may be feeling vulnerable and perhaps ignored. Including the patient and/or family in what is happening is how to truly practice patient-centered medicine.

Comment 1#

This is the $1,000,000 question. A lot of people would like to know the answer.

Comment #2

Very insightful. I think this provides an excellent framework for understanding behavior such as the patients; and much more nuanced than simply "weakness of will"

Comment #3

This is extremely interesting; and based on your example, I would agree that patient education will often produce "descriptive judgments," using the philosophical nomenclature.

Comment #4

As usual, I've learned something from this latest interaction with you. I found your essay extremely thought-provoking. You - and philosophy! - provide a very useful framework for understanding the apparent paradox of patients "understanding" the implications of not adhering to the medical treatment plan; while persisting in that non-adherence.

You ask the key question: how can physicians help patients switch from descriptive to evaluative judgment? Perhaps the answer lies in the definition of that messy region, "the better option, ALL THINGS CONSIDERED." At the least, this should lead to an interesting discussion!

Comment #1

Interesting comment. It is easy to become inured to suffering and injustice, especially when it is the norm, and to think that these stories don't matter. They always matter.

Comment #2

In reading about these women, I feel great empathy and also anger at their plight. It also reminds me of the thousands of stories physicians carry around in their hearts. These stories do not disappear, and they need to be shared.

Comment #3

This is an excellent point Beatrice. It is true that in these contexts medicine became an instrument of power enabling neglect and mistreatment of women.

Comment #4

Another very perceptive observation. Systems of any sort, including healthcare, tend to operate in ways that support the power structure of the status quo; and they can corrupt our own values and priorities unless we are vigilant.

Comment #5

Indeed, a wise and humble conclusion.

Comment #6

This is an excellent essay. You did a wonderful job of analyzing your patient's sharing on many important levels. You understood how medicine had, in some ways, become a tool of oppression to maintain women in a grossly unequal cultural situation. You also realized how, when certain practices are normative and expected, it is easy to become desensitized to them. Further, you were aware that your patient carried the burden of these stories, these acts in which she tried to do the best for her patients but was still complicit in an unjust social structure, and that by listening you helped lighten her load.

Comment#1

This is just heartbreaking. What should be a joyful occasion is transformed into grief and devastating loss.

Comment #2

Hmm. I'm not quite sure I understand the role that religion played - did the mom believe that God would intervene to save her babies?

Comment #3

I can hear your frustration that, apparently because of her religious convictions, the mother put her own life at risk. Your question is born out of that frustration. People have very different worldviews and belief systems. Science is one and faith is another. Sometimes these worldviews collide in frightening ways. They only have a chance to be reconciled through taking time and making an effort (of course in the case of a minor child whose life is endangered by religious beliefs, legal remedies are available).

Comment #4

I understand your frustration that this patient put her own life in jeopardy in the belief that, if she avoided delivering, God might save her children. People make all sorts of choices based on belief systems that seem incomprehensible to those who do not share those beliefs, but are commonsensical to those who do. When the patient is a competent adult, it is only by trying to enter their worldview and finding an argument that is convincing from their perspective, that you can hope to find a way forward. Sadly, as for example for some very devout Jehovah's Witnesses, this is not always possible.

Comment #1

Good self-awareness, Brian. These are natural emotional responses. How do you think they might affect the encounter?

Comment #2

Welcome to medicine. So long as you feel torn, you are okay. It’s when you prioritize your own medical agenda at the expense of the patient’s priorities without a second thought that you are in trouble.

Comment #3

They are not exactly mutually exclusive (keep your eyes peeled for experienced physician role-models who can do both) but they are often in competition, and the rewards of the system emphasize efficiency and productivity over kindness and caring.

Comment #4

This is a very honest, unblinking self-assessment. Don’t judge yourself too harshly, but do pay attention. This is where the learning occurs.

Comment #5

Speeding up clinic is not a bad goal. Sometimes this can happen without cost to a patient. The trick is to be “light on your feet,” and to adjust your expectations according to changed circumstances. If this patient needed to tell her story, then maybe you can pivot to listening; and clinic will just run along in its rather dilatory manner as it usually does ☺

Comment #6

I am confident that you will. The fact that you noticed this issue in yourself is a positive sign that you will remain committed to seeking out that balance – which is not easy, but usually is possible.

Comment #7

This is an excellent thought to keep front and center to guide your behavior.

Comment #1

This is a difficult situation indeed. Yes, you have an obligation to provide care for all patients, even racist ones. On the other hand, you may feel you also have an obligation to advance inclusive environments and not collude through silence with racist beliefs. The latter might be especially true when such beliefs are actually compromising the care of the patient (i.e., refusal to be treated by a competent physician of another ethnicity or background). Especially in a continuity care situation, this is an issue that could be caringly but honestly addressed with the patient. "I know you're concerned that this psychiatrist has an accent (or is not white), but this is someone I think could really be helpful to you. Can we talk about how your worries may be restricting the quality of care you receive?"

Comment #2

Dr. Craemer is awesome and a great role model.

Comment #3

Dealing with a racist patient presents challenges somewhat different from dealing with a racist person. You have an obligation to care for and treat. Many physicians believe this obligation overrides all other considerations, and wherever possible, the patient's wishes should be

accommodated. However, others feel that, while care should never be compromised, it is morally problematic to keep silent in the face of blatant racism. There are different ways of doing this, depending on the way in which the racism is expressed (I offer one possible idea). There are more stringent steps that can be taken as well; for example, rejecting patient's racist language directed at a colleague or hospital worker (see attached). I think the most important thing is to think this through in light of your own values so that when such a situation occurs again (and sadly it will) you will have some ideas about how to proceed.

Comment #1

This was a good thought on your part. As of course you're aware, different families and different cultures have different comfort levels in terms of privacy of sensitive information. Many Western cultures, for example, are more oriented toward individualism and autonomy, while certain other cultures place more value on the familial and the collective. I wonder if there was any way you could have determined how the patient felt about the conversation without offending the gathered relatives, who were clearly there to show support and express concern.

Comment #2

I think you make a good point. It seems a stereotyping generalization to assume that all "Asians" want multiple family members present during medical conferences. There is often a generational factor to consider as well. Older patients may want the presence of trusted family members, while younger generations may have a different view. The main thing is to find out the patient's true desires, and then explore together ways of meeting them.

Comment #3

All excellent observations. We should never treat others as merely representatives of a group. It is always important not to make assumptions about anyone, but take care to recognize both their individual and cultural identities.

comment #4

My view is that you showed a well-placed sensitivity in thinking about this issue. Focusing on the patient's health is paramount, of course but part of promoting health is creating an environment in which the patient feels safe and respected. If the team had already ascertained the patient's comfort with the large number of people present, than they did the right thing and you were just playing catch-up. If, however, they simply did not consider the patient's perspective, then I think you were ahead of the curve. Treating people as unique individuals, not simply as products of their upbringing

and culture (although these are vitally important to be aware of), nor simply as a canvas for their disease, is part of being a good doctor.

Comment #5

You've written a very thoughtful essay about treating patients as individuals vs. as representatives of their culture. In truth, the answer is probably both/and. We have simultaneous individual, familial, group, and cultural identities. You make an excellent point that we should not make assumptions about patient preferences based on cultural or racial categories. This is demeaning and a kind of stereotyping. On the other hand, we must respect others' cultures even when they lead to choices or perspectives at variance with our own. Too often, the medical system simply ignores such issues, but does so at its peril. You cannot take optimal care of a patient until you know their preferences, wants, and needs. As you astutely point out, these are influenced by race and culture, but also by individual temperament, beliefs, life experiences, etc. In this case, respecting the family is important; and finding out the preferences of the patient is also important.

Comment #1

This is a key issue to examine. It is hard enough for doctors to effectively communicate with patients even when they share a language. Adding language barriers makes a complicated situation even harder.

Comment #2

You are wise to recognize that both information and empathy are often casualties of language discordance.

Comment #3

Yes, and this sense of time pressure often causes residents and physicians to rush through the encounter.

Comment #4

I appreciate that you managed to find empathy not only for your patient but for your interpreter as well. Hospital interpreters are supposed to be trained to be familiar with medical terminology, but this does not always cover all situations. Poor translation, as you sadly discovered, compounds the anxiety and distress patients feel when they cannot adequately communicate with their doctors. Learning Spanish is an important step that makes patients feel safe and valued; and allocating sufficient funds for well-trained interpreters is also key.

Comment #1

So the patient's agenda is obtaining benzos. This will of course make the encounter difficult. It is important to set clear limits with a patient pursuing this goal, while not shaming or punishing him.

Comment #2

Of course he is feeling anxious because of the loss of his job, his dependent children, and his health issues. But Xanax is not going to solve these problems, and will likely dig him in deeper. There are other ways of managing anxiety, although likely your patient will not be receptive to them.

Comment #3

Actually, this is very nicely stated. He's come a long way and he has a long way to go. Both messages are important.

Comment #4

I think you both could agree on the value of this goal - you would just see different ways of getting there.

Comment #5

That is a valuable message to try to convey. I've seen physicians give a limited opioid/benzo prescription to help the patient "get on track" and settle down enough to address his medical issues. I'm not sure that would be effective here, given the patient's past history. It is very frustrating, but all you can do is use the levers you have to persuade him in a more positive direction. With his past history and a wife taking Xanax, it's going to be an uphill struggle, but one worth attempting.

Comment #1

You can hear that the patient has a vulnerable relationship with the healthcare system. How might you begin to counteract some of her beliefs?

Comment #2

The need to be believed, to be taken seriously is important to all of us. The patient's pain may have been psychogenic, but it is very real suffering nonetheless. Recognizing this may lead to nonharmful interventions that may help the patient improve.

Comment #3

Interesting choice of words. When patients feel their doctors don't care about them, or that their diseases are difficult to resolve, they fear abandonment. It may also be the case that fear of abandonment is part of the patient's personal dynamic, which will have to be monitored to ensure it does not lead to an unhealthy dependency in the relationship.

Comment #4

It was heartening to read that the resident handled this difficult situation so well. It is always difficult when the patient has medically unexplained symptoms - this tends to make the physician, as well as the patient, feel helpless; and eventually it becomes easy to blame the patient as a somaticizer, a malingerer, or just a "head-case." Of course, these are real possibilities, but dismissing the patient as having "nothing wrong" is never a good way to proceed. There can be pitfalls in these relationships, but a wise physician learns how to navigate them so as to support the patient while not colluding with her.

Comment #1

This role gives you an invaluable perspective in understanding what it is like to be a non-English-speaking or limited-English-speaking patient dependent on interpreters or phones to convey your concerns.

Comment #2

It sounds like you made a valiant effort, so don't blame yourself. Nevertheless, I have often see the same phenomenon in clinic myself. Limited language skills can lead providers to erroneous conclusions. The solution is more bilingual physicians and more interpreter resources.

Comment #3

I'm impressed with this careful analysis of what nonverbal and verbal behaviors on your part might of created different patient responses. You actually learned a lot by reflecting on this situation, and fortunately, no harm done.

Comment #4

Very nicely put. Even when provider and patient share a language, attention to these nonverbal markers is essential in providing optimal care.

Comment #1

I wonder what you learned about your patient in those few minutes?

Comment #2

Do you think she was simply not focused on your questions, or did you suspect some cognitive impairment?

Comment #3

Ah, this is well said. As a med student (or physician) you have a certain agenda - to "get the pieces of information you are after". But the patient also has an agenda - yes, perhaps to get help for her pain; but perhaps also to have someone listen to her, "see" her as a fellow human being. Somehow these agendas must be reconciled.

Comment #4

This patient is a classic "poor historian" - but when we use that kind of language, we are blaming the patient for failing to conform to the medical system's hierarchy of priorities.

Comment #5

No question these are extremely challenging situations. I will be interested in hearing your ideas on Th. Depending on the patient's cognitive status, you might consider enlisting the patient, i.e., making common cause with the patient: First, acknowledge and appreciate the patient's stories. Second, emphasize that specific information in response to specific questions will help you to take better care of her. Again, you are looking for ways of bringing the patient's view of the encounter and your own into greater harmony.

Comment #1

Very empathic narrative. You are telling his story, not simply summarizing his clinical case. Well done.

Comment #2

Great insight! What a heartbreaking metaphor.

Comment #3

Very well done: “Depression was the cause of his bedsores.” This is where the intervention needs to occur.

Comment #1

I would be very curious about the approaches you tried. This is a challenging dilemma that stumps many experienced clinicians. As you can imagine, it is very hard to eliminate traditional foods from your diet.

Comment #2

This is really, really well said! You've understood exactly at a deep level what is going on with your patient.

Comment #3

You state very well why it is often not a simple matter to recommend dietary changes. Food is a key symbol of family, culture, and tradition - plus it is delicious! Separating someone from their food often means in a way isolating them at mealtimes. It is not that we should refrain from dietary discussions out of respect for a patient's culture; but rather that we should work with them - and with the community - to seek culturally sensitive solutions.

Comment #1

Fascinating outcome. Thank goodness someone made the effort to involve the pcp. Think what might have happened otherwise.

Comment #2

Yes, I agree with you completely. I think it comes down to trust, and these factors (language concordance, shared cultural background) contribute to trust. It is worthwhile considering how, in the absence of such commonalities, trust can be established.

Comment #3

Good point, which suggests that, especially in serious situations, even when the pt speaks some English, it is a good idea to involve an interpreter.

Comment #4

You were really paying attention not only to the content of the exchange, but what was happening on a meta-communication level.

Comment #5

Indeed, and I think you are implying that when doctor and pt share a common cultural background this can happen more easily.

Comment #6

Thanks for this interesting reflection on how language and culture (and trust) can transform a pt encounter. I appreciated that you were such keen observer of the change in Mr. K when he spoke to his pcp (and by the way, brilliant idea on someone's part to involve this individual). There is no doubt that shared language and culture engenders trust and improves communication, which speaks to the importance of diversity in the physician workforce. An interesting question becomes, when these factors are absent, how does one go about building the trust essential for good patient care? It is very hard to do in intense situations such as an inpatient setting when the pt is facing an unexpected possible diagnosis of cancer, but perhaps by listening to his story, learning more about him personally, groundwork could have been laid. In this case, the outcome was the best possible due to the intervention of his pcp.

Comment #1

These are all actually beautiful thoughts, Christina, and I hope you will consider verbalizing at least some of them to your patients.

Comment #2

Both your excitement and your frustration make sense. The patient's problem was one of the reasons you want to be a doctor, and here you are, able to help her! BUT - you struggle to understand and can't get the facts you need in order to move forward.

Comment #3

These seem like excellent questions, and fairly straightforward. Looking back, do you have any thoughts about how you might have approached the patient to obtain better answers? Where do you think the problem lay?

Comment #4

These language-discordant situations are very frustrating. I think you learned some valuable lessons, including patience with an inefficient and aggravating process and commitment to continue to

improve your Spanish. In the meantime, developing skills to take full advantage of interpreter services can also ease the burden.

Comment #1

Very conscientious; and could save a lot of time down the road.

Comment #2

Yes, the language might vary, but the feeling of anxiety and worry about miscommunication are the same.

Comment #3

Good, you were doing exactly the right thing - you paid attention to his nonverbal cues, and tried to adapt your communication based on your pt's comprehension

Comment #4

A great exercise in empathy, Christina, trying to put yourself in the pt's shoes.

Comment #5

Indeed, this is of great benefit, especially when the family member recognizes that they are there to assist, not to dominate.

Comment #6

Lovely. Too often the physician regards the family member as an impediment whereas in fact they can be a great resource.

Comment #1

Given his religious delusion, I don't imagine either of these approaches would be too convincing.

Comment #2

Very well said. This is an especially difficult dilemma with psych patients, who may or may not lack competence or capacity to make their own medical decisions.

Comment #3

I assume he was also refusing psychiatric medication

Comment #4

A very wise acknowledgment of limits.

Comment #5

This is without question a difficult and frustrating situation. From a medical perspective you did what you could to keep him safe; and you gave him medical information which you hoped would inform his decision-making. I wonder what it would have been like to meet him on his territory - i.e., to engage in a theological discussion so to speak: Is this what Jesus would want from his adherents? Might there be other ways he could show his religious commitment? Perhaps involving the chaplain could have helped. I realize that this is not a religious issue so much as a psychiatric issue; but perhaps by starting with where the patient was, you could have found common ground. And perhaps not. Such situations are very difficult to resolve.

Comment #1

I think your analysis is exactly right. The only caveat I'd add is that seeking additional drugs is probably how the patient thinks he will "feel better" - unless he is selling drugs, which is a whole different story.

Comment #2

Again, I hear where you're coming from. There is nothing more challenging than patients seeking opioids. However, he may not perceive himself as taking advantage so much as looking for a solution to his suffering. He may see himself as in "genuine need."

Comment #3

I think these feelings are so natural and understandable. Drug-seeking is a very frustrating problem to deal with.

Comment #4

Ah, exactly. You are seeing this, in my view, in exactly the right light - which does not mean you should refill his prescription, but does imply you should treat him as a fellow suffering being.

Comment #5

This attitudinal nuance is so important, Connor. It is ultimately a medical decision whether you should prescribe a "tide-over" dose of narcotics or not; but HOW you arrive at this decision is really essential in being able to see clearsightedly what is in the best interest of your patient.

Comment #6

I think many physicians feel ill-equipped, which has contributed to our current opioid epidemic. The need for opioids is so powerful that it is very difficult to "redirect" these patients to other resources

(often not easily available) to deal with their addiction. But there is no contradiction between recognizing the suffering of your patient while setting limits that are in his best health interest.

Comment #7

Thanks for sharing such an authentic struggle with a patient who likely frustrates most if not all of his providers. I agreed with your analysis - he sounded like he was fabricating in order to get additional opioid prescriptions. As you noted, it is easy to feel "anger and disdain" for this sort of manipulative behavior. Yet the conclusion you came to is far more nuanced and humane. This man is suffering and seeking a solution - not unfortunately a good one, but the best one he can imagine. A compassionate compassionate physician sees this, empathizes with his pain (although as you said, may not really fully understand), and attempts to offer healthier alternatives - which will likely be rejected, but occasionally will be accepted. You can refuse to dehumanize such patients while also setting appropriate boundaries.

Comment #1

Interesting. Many people refuse hospice, but not usually when they are reconciled to the end of life. I would like to understand his refusal better.

comment#2

This was an important discovery on your part and the part of the palliative care team. I have seen this same dynamic often - present adult child on board with plan of care; distant adult child opposed. Finding out who has the decision-making power in the family is essential. Good work on everyone's part.

Comment #3

Exactly the right conclusion. I encourage you to apply the lesson you've learned broadly. Resistance to a plan of care or course of treatment is rarely inexplicable, although the patient may not initially be willing or able to explain the reasons. It is always important, as happened so well in this case, to be nonjudgmental and curious about resistance, and make the patient feel safe enough to explain why he or she is "opposing" you. Showing the patient that you will not reject or turn on them despite disagreement sends a powerful message of your commitment to them; and lays groundwork for resolution of differences.

Comment #4

Thank you for this insightful essay. It illustrates very well how cultural factors come into play in healthcare. Issues of different perspectives among family members and who in the family has

decision-making authority arise frequently in end of life planning; and can complicate an already difficult and sad situation. You had the great good fortune to participate in a family conference that successfully uncovered and resolved these complex issues.

Comment #1

Yes, this is a bad news/bad news scenario. You're right, this is so hard to communicate to the patient, yet so essential. At the least, the patient deserves to know where he stands. He also deserves to feel that the physician cares about him and will help the patient find the best path forward.

Comment #2

You are likely very right. I'm sure several people talked to the patient about his situation, but in ways that were confusing, unclear, and allowed room for denial. Unfortunately, physicians often do not do a good job when they have to tell a patient bad news. Yet this is when the patient needs the physician's knowledge and compassion most.

Comment #3

This is a hard situation certainly, but the physician must have the calmness and courage to "be real" in your term with the patient. This does not mean callous and indifferent. Rather, it means recognizing the inevitable suffering that the patient will experience upon hearing the news; and remaining open-hearted and caring rather than closed-off or avoidant.

Comment #4

It is reassuring to hear that, at last, an attending was able to help guide the patient and his wife through the devastating process of truly hearing and understanding his prognosis.

Comment #5

I find the attending's behavior so admirable. Each day, the patient is probably looking for a different answer to the horrible question about his future. Instead of becoming impatient or annoyed ("I've already explained all this"), the attending simply persists with kindness but importantly with clarity. Who wants to accept this answer? Yet by returning each day the attending helps him to do so.

Comment #6

These are all excellent hypotheses. It's important to remember that no one wants to hear they're going to die, and it is natural to resist this information. It is natural to "misunderstand," or "not

remember," or rationalize. This doesn't make the patient a problem patient, just a human patient. It is the physician's responsibility to ensure that the patient has an informed grasp of what is going on.

Comment #7

You may have seen on occasion on the wards where Medicine thinks hem-onc is going to deliver bad news and vice-versa. The dreadful buck just keeps getting passed. It is important for teams and attendings to coordinate so the patient receives clear, non-contradictory information, and all too often this does not happen.

Comment #8

In this difficult situation, I'm glad to learn you had the benefit of a compassionate and honest attending. No matter whose job it was to inform the patient of his prognosis, it became the job of your attending as soon as she became his doctor. These instances are not rare because of how hard it is to impart such difficult information; and how hard it is to receive it. This difficulty, however, does not let the physician off the hook. It is often not enough to simply "tell" the patient. The physicianmust be willing to return - again and again, as your attending did - to this painful topic, to assess how the patient is processing the information, whether the patient has new questions, how the family is coping etc. Learning how to be "present" with a patient during such immensely challenging moments is an essential part of being a good physician.

Comment #1

The patient does not seem very sympathetic. These are the interesting situations where it takes some work to muster empathy.

Comment #2

These emotions are of course completely understandable. She was rude, uncooperative, demanding, and even abusive. Who would feel empathic in that situation? Yet it is worthwhile asking how your anger and disrespect for the patient will affect the care she receives. This is the dilemma we try to resolve.

Comment #3

I would be interested in learning more as to how the team "handled" the patient.

Comment #4

This was obviously a very frustrating encounter and I appreciate your clear and honest identification of the emotions you felt in regards to this patient. I think they are feelings most physicians would have in response to her lack of cooperation, demandingness, and verbal abuse. One thing to keep in

mind contextually is that this very unpleasant patient is nevertheless also a suffering human being. She is trying to alleviate her misery in the only way she knows how (drug use and drug seeking). While not colluding with her misguided attempts, her physicians need to recognize her suffering, regardless of its causes, minimize judgment and understand better what she really needs. I agree with you that a busy trauma service is an unlikely setting in which this can occur, but perhaps being curious about this patient could suggest ways of providing her real help.

Comment #1

It's very sweet that you noticed this nonverbal exchange; and also important. It gives you important insight into the relationship of Mr. and Mrs. T. What did you think this exchange said about their relationship? How could this be helpful in guiding your care of these patients?

Comment #2

Agree, especially managing a chronic condition like diabetes. I wonder if there is any way of coordinating with their physician in American Samoa?

Comment #3

Exactly, cultural expectations and habits around food are almost universally the opposite of what a diabetic diet requires! Even if your patients did not live on American Samoa, this would be a challenge. How do you think it might be approached?

Comment #4

This was both an unusual and a familiar dilemma: unusual in that your patients only came for treatment once or twice a year and lived outside the continental US!; familiar in that nonadherence to insulin therapy and dietary constraints are widespread challenges in the treatment of Type II diabetes. Encouraging people to modify their eating habits while not stepping all over their familial and cultural customs is a fine line. Often it is best approached from a group perspective, i.e., soliciting family and even community support. Structural determinants of healthcare suggest that it is best approached from a group perspective, i.e., soliciting family and even community support. Structural determinants of healthcare suggest that it is important not to conflate respect for culture with acceptance of unhealthy lifestyle practices but to help patients, families, and communities devise culturally appropriate ways forward.

Comment #1

Maybe this isn't quite how your attending phrased it, but this sounds a little punitive. Am I misunderstanding?

Comment #2

I can understand why. This sounds like a pretty big step that the patient was not prepared for.

Comment #3

It sounds as though your attending was trying to do what was needed, but that this interaction fell short because of time constraints and communication issues.

Comment #4

Honestly, this makes no sense. If the physician does not do an adequate job of addressing the patient's fears and concerns, the likely outcome indeed is nonadherence to a new and upsetting regimen. I wonder whether there would have been a better way to approach this? Did the attending have an interpreter available? Might the limited time have been better spent preparing the patient for this transition, introducing the idea of insulin and injections more slowly, and giving the patient time to express her concerns. In the end, taking a little extra time will benefit the patient. Otherwise, it is going through the motions. In the EMR everything has been done, but in real life not nearly enough was done.

Comment #5

I found this account quite distressing, but not completely unfamiliar. I am not blaming your attending, who probably was doing the best he could given the time and language constraints; nevertheless, this was a failed encounter in your description. The patient left frightened and unconvinced about the proposed treatment plan, and it seems unlikely she seems unlikely she will start injecting herself with insulin. In this case, the physician must reconsider how to resolve the difficulties of language and a busy practice in order to ensure the wellbeing of his patients.

Comment #1

Did you feel that the medical care she was receiving in Mexico was inferior to that which she was receiving in the U.S.? Was it that it was almost impossible to successfully reconcile the approach here with the approach across the border?

Comment #2

This is certainly understandable. Physicians want to provide optimal care to their patients. Sometimes they are hindered because for a variety of reasons patients do not scrupulously follow-through with physician recommendations. This happens with all sorts of patients, but can certainly be exacerbated when there are cultural/linguistic differences. Since this is not an uncommon occurrence, the challenge is to figure out how to improve follow-up so doctor and patient are working together.

Comment #3

These comments show great self-awareness and humility. I really appreciate your openness. Recognizing that we have "room to grow" is a very admirable place to be.

Comment #4

This sounds like a difficult situation both medically and socially. The resident seems to have been thoughtful and sensitive on both dimensions.

Comment #5

Good point, and I think many times physicians avoid talking about cost issues out of a concern to protect the patient's self-esteem. However, it is vitally important that physicians understand financial barriers to care, and to create an emotionally safe environment that allows such sensitive topics to be discussed openly.

Comment #6

I think the key is to have open communication that avoids shaming patients and attempts to problem solve on both medical and financial levels (i.e., by seeking access to low-cost medications, rearranging budgetary priorities etc.).

Comment #7

Excellent observation. This phrase provides patient buy-in; or conversely gives the patient the opportunity to say, this isn't going to work for me. It is less the physician telling the patient what to do and more negotiating a realistic mutually agreed upon plan.

Comment #8

Well-observed. In this case, longevity may not work in favor of the relationship. The physician has made up her mind that this patient is annoying and "difficult," and is not interested in reevaluating this conclusion or in attempting more beneficial approaches.

Comment #9

Although I imagine that this was a very disappointing encounter to observe, there is a lot we can learn from it. What happens when physicians form negative views of their patients? How does that affect their care of the patient? How does it affect their interactions? How can physician's and patient's agendas be better reconciled? What can physicians do to better manage their negative emotions? Medical students think they will never be this physician, but it is surprisingly easy to succumb to frustration, annoyance, and aggravation. The important thing is to recognize warning signs, and counteract, rather than justify and indulge these feelings.

Comment #1

This suggestion might make sense, but as you go on to discover, sexual abuse is still often perceived as a stigmatizing condition in which the victim is blamed. I wonder if professional counseling was suggested. Many people are skeptical about such help, but as you discovered, sometimes a trustworthy stranger can be "safer" than family and friends.

Comment #2

Let me compliment you on creating an atmosphere in which this young woman felt safe enough to open up and discuss her very serious problems. As often happens in primary care, you skillfully uncovered the problems beneath the problems. Your ability to understand the community from which she comes, and its possibly judgmental or gossipy elements, no doubt contributed to your patient's trust. I'm glad you discovered as well that sometimes the physician's role is to witness and support, while helping the patient to find resources that will advance her healing.

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comment #1

This sounds like a very valuable and open conversation. Good for both you and your resident to enable this to happen.

Comment #2

This is a great example of how familial and cultural patterns exert a tremendous influence on individual eating habits.

Comment #3

And no wonder. She is marking herself as "different from" those she loves most. It is sad, however, that no one in the family is supporting her to lose weight. How might you intervene to change this dynamic?

Comment #4

Yes, awareness is a critical first step. What do you think might be some next steps to help this pt avoid the failures she's experienced in the past?

Comment #1

What an interesting experience, and a great example of cross-cultural communication!

Comment #2

I'm so impressed that from a single translated interview, you made such an effort to learn about Deaf culture. Many physicians - and people in general - do not even understand that Deaf culture exists, much less seek to grasp its customs, norms, and expectations. Given the realities of Deaf culture, you can see how issues such as cochlear implants can become much more controversial than they are viewed by the medical community.

Comment #3

Thank you for sharing this window into the Deaf community. I was really struck that you bothered not only to notice the use of ASL, but to take advantage of this opportunity to learn something about Deaf culture - which is, indeed, a culture. You learned a great deal in this brief encounter, and I have no doubt that this cultural sensitivity will carry over with humbleness and respect to other Deaf patients.

Comment #1

What a lovely statement. Think about how you can sustain that sense of excitement or gratitude as you proceed through training, and seeing patients is more and more routine.

Comment #2

Mom may have felt stigma in herself toward mental disability. She may also have encountered it many times from family, friends, society in general, and yes, even health care professionals. You sent

her a powerful message when you signaled that you saw her son as a person that you were looking forward to spending time with.

Comment #3

The pressures toward "normalization" are very great, both in society and in medicine, even if this is not necessarily in the best interest of the patient.

Comment #4

Good observation on your part. The mother's love was as strong, if not stronger, than her sense of shame.

Comment #5

Yes, I think what you're saying is that mom might understand her son's diagnosis and illness differently than her doctors; but her love is something any mother would recognize.

Comment #6

As you realized, this encounter was an opportunity to model attitudes of nonjudgmentalness, acceptance, and welcome toward persons with mental disability. Your authority as an (almost) physician gives added weight to taking a position in contrast to what mom and son may often encounter in society (and perhaps on occasion in the healthcare setting). Your observations of mom were finely tuned: you saw both her embarrassment, her efforts to make her son "normal," as well as her genuine love and kindness toward him. If you were this patient's pcp, awareness of these aspects of their relationship would enable you to tailor his treatment to the strengths of their specific situation.

Comment #1

How did you feel about these actions on the part of the family? Did you feel they were doing what they could to help their loved one? Did you feel they were intrusive?

Comment #2

Again, I wonder what this was like for you to see these little girls. Perhaps social work was involved to help them deal with the severity of the situation?

Comment #3

This is true. At the same time, it is helpful for the physician to be aware of his or her own views on these sensitive topics, so that personal judgments do not complicate the physician's ability to be empathic and connected to the patient and family.

Comment #4

Thank you for your essay. This situation combines many sensitive issues, as you astutely observed - religion, drugs, and gangs. Physicians always strive to be "objective," yet because they are not automatons, this is not always possible. The biomedical aspect of care is rarely affected; but the intangible aspects of empathy, compassion, respect can be influenced by personal values and judgments. I think the best defense we have is self-awareness - if we know our own biases and assumptions, we can be more sensitive to how they may subtly affect our interactions with others.

Comment #1

Good question. Often it does require more; and these are patients who fall through the cracks, who receive emergency MediCal when their cancer has progressed that it is much less treatable. Your question raises many more questions about healthcare in this country; and whether healthcare should be considered a right or a purchasable commodity. One bright side is that, even at a clinic used to treating well-insured, well-off patients, when the need arose, they were sincerely concerned for their patient and did the best they could to help her.

Comment #1

Sensitive observation, Luke. A word like "cancer" dropped somewhat casually can spread ripples of terror in patient and family. We should always choose our language with extreme care, and especially so when there are language differences.

Comment #2

Good insight: a familiar face, even absent a shared language, can be reassuring and comforting.

Comment #3

You clearly were able to establish a relationship with the family, despite limitations of language.

Comment #4

You are sensitive to the extreme vulnerability of the non-English-speaking patient in the healthcare system. As much as possible, their fear and anxiety need to be addressed and alleviated. In particular, the chances of miscommunications and misunderstandings are obviously greatly increased, so care with language is essential. It sounds to me as though you did an excellent job of establishing a connection with the family and the patient, simply by showing up and trying to be helpful to them. Well done

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Comment #1

It's wonderful to see your acknowledgment of the many, intertwining factors that can affect such a decision. It is complicated, but so much better to see this than to dismiss the patient as "not interested in his health."

Comment #2

Yes, I agree that uncertainty is a significant part of medicine, and something doctors must come to terms with.

Comment #3

Very true, and so far as it goes, I think an appropriate ethical stance. The problem, as you well recognize, is that because of all the factors you note, not everyone has the same ability to make informed, optimal choices.

Comment #4

I appreciate the concern you showed for this patient and your worry that he never made it to the ER. Your conclusion is absolutely spot-on, and shows the importance of anticipating difficulties and addressing them respectfully but straightforwardly. "Going to the ER" is not necessarily a simple medical decision. As you understand so well, it can involve multiple, structural, cultural, and financial factors. If the physician is not at least aware of the potential complexity of this decision, and probes a bit further, as you suggest, the patient may be unwilling or unable to raise these questions for him or herself.

Comment #1

That was both a very thoughtful and very kind statement. Even if it did not help Ms. Nguyen (and we know so little of what patients in these states experience), it would certainly be healing for her family.

Comment #2

Yes, a wonderful insight; and you enabled the family to do this in culturally appropriate ways.

Comment #3

I am always wary of calling an EoL situation a "good death," but this seems like a pretty good death to me, in that the NCC made space for practices and customs that brought consolation to the family (and perhaps to the patient). I think you had the opportunity to witness a peaceful passing according to time-honored traditions. It's a wonderful example of how healing can occur even at the end of life.

Comment #1

One issue that comes up in clinical medicine is which battles to fight. If this water is benign, it may not be a problem that the patient attributes benefit to it, so long as she does not rely on it to the exclusion of medicines of proven value such as her HTN meds.

Comment #2

You are very sensitive to your patient being exploited by people who stand to make a buck as a result of her gullibility. I wonder if this would be a conversation you'd consider having with your patient, coming from your genuine concern: "I'm worried that people who have a vested interest may try to persuade you to buy products that are unnecessary or more expensive than a simpler form. What do you think about that?" These individuals are trained to win customers' trust and play on their fears. Without attacking the salesperson, you could at least raise these issues with your patient.

Comment #3

Many patients are uncomfortable taking medications, and believe that "harmless" alternative remedies are preferable. Often these strongly held beliefs need to be explored openly and nonjudgmentally, and a treatment plan agreed upon that respects the patient's desires while protecting their health to the extent possible.

Comment #1

This is an interesting comment that probably deserves further exploration. What made it such a bad experience she doesn't want to give it another try?

Comment #2

Although education is the fallback of all physicians, in this situation I'm not sure that's what's called for. Undoubtedly this patient has heard it all before. So what's the barrier? What might motivate her to overcome it?

Comment #3

Of course, we can label this denial, but the more interesting question is how can it be chipped away at? So long as the patient feels these bad consequences won't happen to her, why should she change her behavior?

Comment #1

You really went the extra mile with this patient. You were doing everything right. I just wonder whether he had capacity to guide his own care?

Comment #2

Indeed you did, and you should be proud that you managed to make the dent you did in his paranoia and delusions. Given the circumstances, I don't think you could have overcome these simply through cultivating a good doctor-patient relationship.

Comment #1

Interesting statement, it kind of goes along with her depressed affect. I wonder if she was willing to share her thinking about this with you.

Comment #2

Agree - your patient has a life-threatening condition. What steps can you take to ensure her safety

Comment #3

Again, very valuable information. Many people dislike and distrust psychiatrists - how can the pcp help shift this perception? For someone who is depressed, pursuing a referral can indeed seem like a great deal of work - how could this burden be lessened?

Comment #4

Excellent insight! I never thought about depression from quite this angle, but this is really a good point.

Comment #5

Again, very well said - both frustrated for her and because of her. It is often easiest to focus on the latter frustration and blame the patient when it is at least in part her disease that is driving the situation.

Comment #6

Great question. I would like to hear more of your thoughts on this point. Ideally, this should be the beginning not the end of the conversation.

Comment #7

Part of this is empathy, acknowledging how difficult it is for them. Part of it is simplifying the task and setting clear priorities - what is the most urgent task that must be accomplished?

Comment #1

Tough dilemma. You just have to try different approaches to get your patient to open up. You could try empathy (it must be hard to sit through these questions when you're feeling sick). You could try asking your questions in a different way. You could try "surfacing" the problem (you seem a little frustrated. Can you help me understand what's going on?). And then when he replies, this is a waste of time and I feel like crap; you can try empathy again (I understand how this can seem like a waste of time - we're trying to make sure we don't miss anything, but I'll go as quickly as I can)

Comment #2

So coming from the world of medicine, you fairly easily understood the NP's perspective - and it was still annoying, but you controlled yourself. Your patient may have no interest in or understanding of the world of medicine, could care less - just wants his antibiotics. So let him know you're trying to cooperate, and that the faster he answers your questions, the faster he'll be out of there!

Comment #3

This is an interesting issue about the taciturn, non-forthcoming patient. We can read the emotions, but we don't know their source. Is it because the patient feels sick? Because he hates doctors? Because he doesn't like to talk? Because he thinks it's a waste of time to talk to a med student? Until you find out what underlies his behavior, it's hard to know how to address it. However, once you've figured out what's bothering him, you can try various different approaches - empathy, negotiation. In medicine, we demand that patients play by "our rules." Usually they do, but sometimes they don't (usually to retain a little power). In these situations, explaining the thinking behind the rules; or even at times modifying the rules can help move things forward.

Comment #1

I wonder at this point if there was an attempt to formally assess capacity. It does seem unclear whether the patient had a full understanding of the consequences of his decisions.

Comment #2

I'd be curious to learn more about how the team handled this expression of racism. All patients, regardless of their views, deserve care. But we set limits on patients' behavior all the time; and I think this is an area where not to respond is in essence an act of collusion.

Comment #3

This is a separate but also difficult issue. The patient needs someone or something to blame, and you all (the medical team) are available. The patient may have had bad experiences with the VA in the past. Also, as you no doubt know, there is a long and ugly history of African-Americans being exploited by the healthcare system, receiving second class care etc. So it can be a complicated issue.

Comment #4

I am interested in whether anyone was able to sit down and engage this patient, human to human. What was his story? What were his fears? It is hard, perhaps impossible, to build trust after a lifetime of inadequate care and social injustice, but the only way to try is through building the relationship.

Comment #5

And again, outstanding. This is a natural, understandable, and WRONG response to a difficult situation, because in the end it is the patient who suffers. The physicians are doing what is comfortable for them, but this does not advance care of the patient.

Comment #6

Wise lesson - and one difficult to implement. Understanding the context of the patient's behavior - while not excusing it - helps soften your own frustration and resentment, and can keep your mind (and heart) open to potential connection.

Comment #7

This is an excellent essay, Megan. You have a superb grasp of all the many factors potentially underlying the patient's inappropriate behavior. Is it possible to overcome these barriers? Perhaps, but by no means certain. The only path forward, as you so wisely see, is not to withdraw or avoid, but to persist in winning the patient's trust. Your response to the patient does not have to be determined by the patient's actions. You can always choose compassion and empathy (even as you impose appropriate limits) instead of blame. In the end, the patient will get better care, and you will be a better doctor.

Comment #1

Unfortunately, I agree that interposing a phone between you and your patient leads to some relational challenges.

Comment #2

Xin, this is an excellent analysis of the factors that limit the humanistic dimension of the phone-mediated encounter.

Comment #3

Yes, this is a very legitimate cause for concern. Residents avoid the interpreter phone in part because it is dehumanizing, but also, as you note, because it takes longer. Even with a shared language, communication between doctor and patient can be complicated. Trying to communicate based on limited language skills can lead to error.

Comment #4

I think the best approach is to use limited language for non-essentials - greetings, small talk, basic information. It's important to recognize when the encounter crosses beyond the threshold of your language competence. Then you must pick up that phone or request an interpreter.

Comment #1

You seem to be critical of yourself in this phrase, but I'm actually impressed with your response. You defused the situation, you owned your MS status, and you pushed back a little by negotiating permission to ask a few questions. Really very skillful.

Comment #2

There is a point somewhere along the line where you need to confront her insulting behavior directly. It is becoming the elephant in the room. I wonder if you could have done that in some way?

Comment #3

That may well have been the best decision; it might also have been interesting to explain in Arabic why you were asking all those questions, to make her realize that her behavior was rude.

Comment #4

Michael, I really appreciate your honesty on this point. A shared culture can be very helpful and can create bonds of trust, but it doesn't solve all problems in the encounter.

Comment #5

Each situation is different, but when it becomes the elephant in the room, ignoring will not likely help it to go away.

Comment #6

A good insight; and if the patient had been able to verbalize this, it might have led to a productive conversation. Maybe she would have preferred a female physician. Maybe she was worried about your inexperience. In any case, if you can create a safe space for patients to discuss difficult concerns, you've made great progress, and are closer to a solution.

Comment #7

I think you handled this well in the beginning; and you might need additional, more direct strategies to surface the problem if it persists (as it did in this situation). Being curious about all aspects of the patient is a good starting point: What is going on here? Why is this patient so rude? So interesting, let's figure this out! Until you are able to help the patient voice the reasons for her discomfort, it is

guesswork as to whether she is uncomfortable because you're a male, because you're a medical student, or because she's having a bad day. Showing your patients you're not afraid to deal with tough issues can engender trust and paradoxically even a sense of safety.

Comment #1

These thoughts show real empathy for what might be going on with your patient.

Comment #2

Nice - you heard her primary concern (doctors are not on her side) and attempted to address it

Comment #3

Your patient thought she saw an opening to manipulate you and seized it. You set a boundary, and this upset her. Nevertheless, I feel you handled the situation exactly right.

Comment #4

: Brilliant. These are your lessons - 1) don't take it personally 2) meet aggression (which is often limit-testing) with empathy and 3) be persistent.

Comment #1

Excellent observation - this sort of superficial glibness rarely results in meaningful lifestyle change for the patient.

Comment #2

This is an excellent point. As well, as you intimate, meals are a family bonding experience; and "separating" yourself by eating different foods, and rejecting foods everyone else is eating, can weaken family ties

Comment #3

This was a culturally sensitive suggestion that the patient might actually follow.

Comment #4

Yes, this is an important point - "demonstrating an understanding." It's always a good idea to let the patient know you get it - "It feels really uncomfortable to try to eat food that is different from what everyone else is eating."

Comment #1

What an outstanding role model, in contrast to people I've heard say, "I didn't go into medicine to become a social worker" (!). Your attending realized that whatever wellbeing remained to this young man would be determined by the welfare of his family.

Comment #2

This is a very important comment, Miriam. When you decide to take action, it is often not straightforward (especially when dealing with big institutions like UCIMC, county etc.). Patience and persistence are necessary. Discouragement is a luxury.

Comment #3

This was a tragic story redeemed (to the extent that such suffering can be redeemed) by the efforts of your remarkable attending, who recognized that he was a healer as well as a physician (!). Helping to restore some small measure of social justice to others is a responsibility of privilege. It is always uplifting to encounter people who understand this. I hope this patient and his family received the help they desperately needed to help them through this terrible time.

Comment #1

What do you think went wrong between your first and second encounter with this patient? What needs of his were not being met?

Comment #2

What do you think the patient was expressing to you? What might he have been afraid of? Why might he have been lashing out and attacking your competence?

Comment #3

Well, perhaps some of both in my view (you may see it very differently). Beating yourself up, shaming and blaming yourself for a difficult interaction sounds excessive and probably not very productive is it lasts for "weeks. On the other hand, if "brushing it off" means not thinking about it or trying to figure out more options for working with a cranky, hungry, upset patients, then this might quash potential learning.

Comment #4 I'm going to push back a little here, but again this is just a personal opinion. The way I see it is that you - and all physicians - are always feeling emotions because you are human beings. It's just at a certain point it is easy to stop acknowledging the emotions, and focus exclusively the biomedicine. The question becomes, does this approach harm the patient - or the physician? An intriguing question to contemplate, and one I hope we can discuss in more depth next week.

Comment #1

Why do you suppose that was? Why didn't your well-intended reassurance not comfort her?

Comment #2

There is no simple, algorithmic answer to this question, but I hope we can discuss some possibilities in class.

Comment #3

Monica, doctors like to fix things for patients; and often they do. But in this case, with a patient who has endured ovarian CA, and whose future is still full of uncertainty, too quick reassurance will probably not comfort her. Giving her this information is good of course - but we cannot expect her to be reassured. So giving her a chance to express her sadness; giving her husband a chance to verbalize his anger; and the daughter to give voice to her fear will help get these emotions out in the open, where they will become less scary. Above all, letting the patient know that her doctors have a plan; and that she will not be alone no matter what comes acknowledges the uncertainty and fear of the patient; and makes tangible your commitment.

Comment #1

What a good idea, Morgan. I'm glad you are still committed to understanding the impact of disease on the patient's life.

Comment #2

Yes indeed pediatrics is as much about care of the parent as it is care of the child. As you know, this postpartum period is one of significant adjustment; and knowing the parents' expectations, health beliefs, and practices will enable you to help them make the transition successfully.

Comment #3

I admired the way you really thought about this patient, and probed the possible implications, positive and negative, of this cultural practice. I also liked that it led to thoughts about the post-partum transition generally, some of the potential difficulties for mom and dad, and how these might be mitigated. I think you are on the path to be a culturally sensitive and aware physician.

Comment #1

I'm impressed that you did this - a first step toward discovering if there might be an approach that would not violate their beliefs.

Comment #2

Absolutely. When physician knowledge and pt/family beliefs collide, it is very frustrating because you are unable to do what you are trained to - i.e., do what is best for your pt.

Comment #3

It does make empathy more challenging. Remember, however, that empathy is not agreement, but fully understanding (respectfully) the other's point of view. Based on the information on the internet, there was probably a certain logic to the mom's position. From her perspective, she was trying to safeguard her son.

Comment #4

Exactly. You are asking family to go against long-held, cherished beliefs; to go against their community and social support. "Evidence" alone will rarely be sufficiently compelling in such circumstances.

Comment #5

It is not so much whether it is crossing a line as whether it can be effective. In this case, I would look for a crack. Is all Scientology united in an adamant anti-ECT position? Are there ever exceptions made? Is there ever a higher good (i.e., wellbeing of a child) that might supersede the prohibition against ECT?

Comment #6

Ah, this is an essential piece of information. So the family was representing THEIR beliefs, but NOT their son's. In this case, I agree the team proceeded properly to seek a court order. However, it is always valuable first to see if you can find a way to bring opposing parties into agreement. Ideally, you would want the family to be "part" of the healthcare team in the sense of being supportive, cooperative with follow-up and outpt treatment etc. Getting a court order will enable treatment, but virtually eliminates the possibility of a working relationship with the very people who will be caring for this pt in the community.

Comment #7

This is a fascinating case that raises many ethical issues. Given that the pt himself was not a practicing Scientologist, the team likely took the right step by seeking a court order to proceed with ECT. Nevertheless, a court order is not something to be undertaken lightly, as it solves the immediate problem (of treatment), but may create additional problems down the road in terms of doctors and family working together to care for the pt.

In terms of your point about empathy, I completely agree that such an illogical position on the part of the parents is very frustrating for the medical team. Yet even under these circumstances, the more you can listen to mom, respect her reasoning (even if you disagree with it), recognize she is trying to protect her child, and continue to look for common ground, the more likely there is to be a positive outcome for all concerned.

In this case, given the mother's adamant beliefs, this simply may not have been possible. In that case, your first duty is toward your patient, and the team proceeded properly in trying to obtain for him the help he desperately needed.

Comment #1

They sound terrified - their beloved family member is very ill, and they are fearful they cannot manage her pain and her general care. They are confronting language and likely cultural barriers as well. Unfortunately, their distress is expressed as demandingness and frustration. This is not uncommon, and shouldn't be taken personally. Instead, it's impotant to understand what the family members fear, and what they need to feel safer and more in control. It doesn't sound like this happened.

Comment #2

Fascinating - night and day. Perhaps this happened because you took the time to sit with them, give them detailed information, answer all their questions, and not treat them like pariahs.

Comment #3

Exactly right. As you discovered, many of these apparently intractable situations can be turned around.

Comment #4

Thankfully you got right to the heart of the matter. This family, which seemed demanding, was really suffering and scared to death. When someone (you) talked TO them, instead of ABOUT them, they tried to cooperate and were responsive. This is an excellent reminder of how easy it is to pigeon-hole people into "difficult" or "compliant," when a lot of these behaviors are brought out by circumstances. If you want a more cooperative patient/family, a good place to start is always your own behavior. I also liked the way you reframed "demandingness as "persistence" on behalf of their loved one's wellbeing. Very nice all around.

Comment #1

This is an interesting statement. What's changed for the patient? What is the back story? Why can't he sleep any longer? How can the underlying issues be addressed?

Comment #2

This is very likely true, but you have to go deeper. Is Xanax longterm going to be an appropriate treatment for insomnia? What is likely to happen to this patient over time?

Comment #3

Sleep hygiene has proven efficacy. Yet it may not full address the problem. It's always important to know what you are treating.

Comment #4

This is a too-common dilemma. The patient has a problem and has discovered that an opioid or benzodiazepine "helps." And they're right - initially. But as you well know, this is the slippery slope down which all too many patients slide these days. Some physicians under these circumstances might prescribe a very short course of Xanax, as an opening gambit with the patient, but probably not. At some point the hard work of figuring out why the patient is not sleeping; and building back good sleep habits will have to be done. You can - and should - empathize with the patient's distress and frustration that the medication that "works" is being withheld. But you can also be honest - help

him understand why you are not writing the scrip and why you and he working together must find another way. It is hard to tell from your story whether the patient is more interested in sleeping or in the Xanax, but regardless you must always take the best, not the easiest, path for the patient's wellbeing.

Comment #1

It will be interesting to see if this happens. This example shows how procedures from one culture do not always translate well into another culture, even with the best intentions.

Comment #2

It might be helpful to better understand how topics of death and dying are approached in Cambodian culture; and how the family can be prepared to deal with the expectations and assumptions they will encounter in the US healthcare system when their mother becomes seriously ill.

Comment #1

There is a lot of disillusionment, disappointment, and bafflement in this experience. How could doctors and dentists miss an increasingly advancing likely head and neck cancer? How could family ignore the severity of their loved one's deteriorating condition? Although there are probably answers to these questions, they will not be satisfactory. We are faced with limits of caring in a way that is highly unsettling. I suspect factors of insurance coverage, poverty, cultural bias, and family dynamics may also have played a role in this truly tragic outcome.

Comment #2

Very well said. I suspect that part of the reason that so many doctors missed this diagnosis is that they became trapped by their own assumptions and expectations. You drew excellent conclusions from this distressing case, which hopefully will serve your future patients well.

Comment #1

Not knowing the patient and her history, this may have been easy to miss. What were the questions your attending asked that elicited this information? What did you learn that might help you in a similar situation next time?

Comment #2

Absolutely. I agree. Taking on this responsibility requires patience and humility, because despite best efforts, the outcome is uncertain. Still, who else will make this effort?

Comment #3

Not this time at any rate. And it sounds like you did absolutely everything in your power, used all the skills and techniques available, to maximize success.

Comment #4

This is a fair and honest comment. How can anyone really feel good knowing that it is unlikely the patient will pursue the help she needs?

Comment #5

you are so right, this is a very frustrating and discouraging situation. There are remedies for missing an important aspect of the patient's situation; and next time you will be alert to considering all possible complicating factors (for example, we know that patients with a history of depression often self-medicate with alcohol and drugs, so it probably makes sense to inquire about their usage). What is harder is providing motivation to a patient who is not at that point in her life. You can - as you did - use motivational interviewing to tease out those parts of the patient that are urging her to change, but they may not be enough at this time. That is where the importance of relationship comes in. If the patient trusts you enough to return to you for care, then this means another opportunity to pursue her addiction and the possibility of change. Continuity of care means never giving up hope for the patient, even when the patient has given up hope for herself. Things change - and perhaps so will the patient.

Comment #1

I am sorry you had to endure this extra stress; and glad that your own background and experiences often helped you to connect with some of the VA patients.

Comment #2

Very skillful. "Getting to know" the patient, which is the cornerstone of meaningful relationship, may reveal uncomfortable differences. You did not engage in pointless argument, but looked for common ground; and amazing found it. Good for you. There should be more conversations like this in the country.

Comment #3

I'm impressed with the way you handled this challenging situation. Rather than take refuge behind the white coat and retreating into biomedicine, you carefully calibrated a genuine response that I think deepened your connection with your patient, and showed he could trust you because of your commitment to the wellbeing of those in need. In the course of your career, you will have to care for patients who are prejudiced, racist, or simply hold very different views from your own. Figuring out how to navigate these situations with kindness and integrity is just another facet of becoming a physician. Well-handled.

Comment #1

Of course, it is the role of the physician (or medical student) to counsel patients about deleterious life-style choices that are injuring their health. As a thought experiment, think about this situation from the patient's perspective: Here you are, not even a doctor yet, probably only a few years older than the patient, and you are telling him how to live. It would be easy for him to be defensive and dismissive. How can you set up this scenario to maximize your chances of connecting with the patient and getting him to listen to you?

Comment #2

You are completely right, of course, that this is an entirely inappropriate question. Why do you think he might have asked you this, other than that he had "psychiatric issues"? Perhaps he felt you were asking him inappropriate questions - and in a way, absent the medical context, one could say you were "meddling" in his life. Context is everything, but he may have posed this question as a reflection of his own discomfort.

Comment #3

This is actually a fascinating disclosure. So in a way what your patient was doing with his (still inappropriate) question was asking for your empathy. "Do you realize that what you're asking me to do would be like you giving up sex?" Appropriate? No. But a gift? Yes! This statement provides wonderful insight into the struggle of your patient, and lets you know just how hard your suggestions are going to be for him.

Comment #1

This patient may well have some psychiatric issues. At the same time, it is worth considering that chronic illness creates overwhelming feelings of loss of control; and that this extensive monitoring (at least in the beginning) might have been a way to regain some control. It is also worth considering that when medical science cannot explain symptoms, doctors tend to call in the shrinks, which tends to make the patient feel dismissed and devalued. It's a delicate situation that needs to be navigated with tender care and respect.

Comment #2

Good labels - this "enables" the patient because it keeps the issue entirely in the biomedical realm. It does not address her suffering, her frustration, her fear, the complete disruption of her life. It does not restore any sense of control to her.

Comment #3

I agree this is a more empowering approach. I think some acknowledgment of what chronic issues have done to this patient's life would not be amiss either.

Comment #4

Good for you. It is often not either/or but both/and. Patients need help with their psyches as well as their bodies; and if approached respectfully and caringly, a psychiatric consult can add value to the team.

Comment #5

Well said - although in this case I think it was patience coupled with proactive thinking about how best to intervene with this patient.

Comment #1

This is a definite challenge in cross-language/cross-cultural encounters. I wonder if you've been able to find any strategies for building relationship in the absence of a shared language.

Comment #2

There is no question that cross-cultural encounters pose special challenges of communication and connection. I agree that it is often true that patients often feel more comfortable with a physician who is fluent in their language (although if the physician is uncaring and indifferent, a common language is not enough to carry the day). I hope we can discuss in class ways you and your classmates may have discovered to build bridges across these divides so as to be able to create the beginnings of meaningful relationship with these patients.

Diet is a complex issue as you discovered. It is hard to ask people to give up foods that are not only delicious but are deeply embedded in familial and cultural patterns. Improving the health of families and communities with healthy eating community-based initiatives is sometimes more effective. I'm curious to hear more about your "interesting solutions" which I'm guessing have to do with compromise and creativity!

Comment #1

I admire that you are not put off by your patients' initial skepticism, but trust that you can overcome it.

comment #2

This sounds like a real bonding experience for both you and the patient. Again, I like the way you are willing to expose your own vulnerability and lack of expertise (in Spanish) to the patient, and even enlist her help. This will both create connection and empower your patient.

Comment #3

To me, this is a great model for the doctor-patient encounter. Patients have a great deal of knowledge and expertise to offer if only physicians are willing to make room for it in the interaction.

Comment #1

This is worth pondering - not an easy question to answer by any means, but once you've decided you have an obligation to help the patient, then you must figure out how this will be possible.

Comment #2

And this is a great question as well - why are they in the ED or the hospital or the clinic if some part of them isn't seeking help?

Comment #3

And this is perhaps the best question of all: WHY? What underlies this patient's resistant, uncooperative behavior? This is where the key to all the other questions lies.

Comment #4

And this may be where your professional code of ethics and the patient's need for opioids causes an unavoidable parting of the ways.

Comment #5

Wow, you and the team did a superb job of eliciting his reasons for avoiding amputation. Well done!

Comment #6

Excellent insight. And negative judgment is not going to help you take care of the patient any better. I think by addressing his fears, his hopelessness there is a better (although small) chance of finding common ground.

Comment #7

I fully endorse this conclusion. It takes time and patience, and does not always result in success, but it is what every patient is owed.

Comment #1

I wonder what you think it was about Dr. Bota's "conversational techniques" that encouraged David to respond to him.

Comment #2

Awesome. You had a great role model; and you were able to learn from him, apply his approach, and have a breakthrough of your own with this patient.

Comment #3

What an interesting and educational experience (based, as you rightly note, on the very tragic circumstances of this young man). You describe his case with careful attention and empathy. I wonder what you concluded from Dr. Bota's ability to "reach" David. Of course, I am sure some of

this had to do with his skill as a psychiatrist, but I suspect that it also had to do with his skill as a human being. I'm glad to learn that you were able to follow in his footsteps so well.

Comment #1

Thoughtful unpacking of this injunction, Sam. I think you are raising questions about the inherent dangers of some medical interventions, both for patient and doctor (or med student or RT), the risks inherent in intervening to try to make people "better."

Comment #2

I wonder what you learned from this encounter, Sam. Is it that to save the patient (or in this case, merely temporarily stave off death) we often have to nearly kill them? Did it raise questions about EoL? Did you feel compromised in some way that you were the "mechanism of delivery" for this deadly drug>.

Comment #1

Good awareness that daughter might have had a somewhat different perspective than mom.

Comment #2

What an unexpected - and somewhat shocking I imagine - turn of events. You can see mom had had this conversation before, she has all her arguments very well marshaled.

Comment #3

Excellent self-awareness Sarah. You had a lot of very strong reactions - understandably - to this antivaxxer mom. Now we will find out what you did with all these feelings.

Comment #4

That's interesting - so she was prepared for a fight and defanged you before it could even get started. She may have been right - she's likely heard all the pro-vaccine arguments before, so what you are listening for is whether there is a dent in the armor, some approach she isn't familiar with.

Comment #5

I think this is true for very committed antivaxxers - like this mom seemed to be - but it's important to remember that there is a large body of less committed people in the middle who can be influenced in the direction of vaccination if approached respectfully and patiently.

Comment #6

To be honest, I don't think that telling that to mom would have been very effective. It might have resulted in her forbidding her daughter to go into nursing! The potential crack I sensed was the daughter's discomfiture. In a subsequent well-child visit, I might have invited mom to exit the room, then had a heart-to-heart with daughter about the importance of vaccines and how not having them might hamper a career in nursing.

Comment #7

I'm so used to hearing stories about antivaxxer parents of small children, so this was a very interesting twist on that familiar narrative. I agree with you that this mom had committed the entirety of her child-raising to being against vaccination. She is not going to abandon this position now to any rational argument. However, the daughter might be a different story, and this is where it might be more worthwhile to invest energy. Despite your feelings of l'esprit de l'escalier, I doubt you could have made much difference at that moment. A conversation with the daughter, without the mother, might be more productive.

Comment #1

How did this "warning" better prepare you for the encounter?; and how might it have biased you?

Comment #2

Good insight - no matter how experienced and well-trained you are, some patients will question your competence; and you will always find patients and family members who interrupt to try to control the agenda or make sure they are heard.

Comment #3

This sounds like a challenging encounter, Scott. You had to contend with the family member's skepticism, as well as the mother-daughter dynamics that complicated your history-taking. I agree completely that these issues will resurface again and again. I will be interested in hearing your thoughts be interested in hearing your thoughts about different ways you might "intervene" to establish trust and reduce interruptions.

Comment #1

I wonder how you felt about the patient's attitude. Did you feel disrespected, annoyed? While this might not be an issue that you could successfully deal with on a first encounter, if this behavior continued, how might you discuss it with your patient?

Comment #2

This is an excellent insight. I'm not sure that in your first encounter with this patient you could effectively address these lifestyle issues, but I would be very interested in hearing how you might approach these issues if you were to function as his continuity pcp. Clearly it is very important that they be addressed, yet how to do so is not simple.

Comment #3

Your essay raises two interesting, and as you point out frustrating, issues. One is how best to ensure that patients respect their physician's time and engage fully in the encounter. The second is how to talk about difficult lifestyle changes the patient should make in order to protect his health. In both cases, the physician needs to become comfortable initiating uncomfortable and upsetting conversations in a way that the patient feels supported and respected rather than blamed and shamed. We will have a chance to discuss how to do this in class, but there is no guaranteed formula, although for the latter concern, motivational issues offers many helpful insights.

Sean, I meant to comment as well that we might fruitfully question whether all physicians can do is educate and equip their patients. Part of the doctor-patient interaction is to help patients see their problems in a different light, and to help guide them to wanting to make changes. This is not always possible, but can arise from a relationship in which the patient trusts that the physician is truly committed to his wellbeing.

Comment #1

Great question to ask. Be curious about your patients, even their frustrating behavior. There are always "reasons," even if they may not make sense or appear justified to you. Understanding is always better than not understanding.

Comment #2

Exactly. Very well said. You go on to ask great questions. It would be great if someone had asked these questions earlier, because as you realize, the patient's resistance to certain aspects of his care makes it harder to help him.

Comment #3

I'd be very cautious in applying this phrase "not caring" to patients. In many years of observing doctors and patients, I've rarely seen patients who truly "don't care" about their health. It's just that their "caring" might be a lower priority than the doctor wishes, or it might take a different form than the doctor expects. Labeling patients as "not caring" about themselves can quickly become a rationale for the doctor not caring about the patient.

Comment #4

Oh my goodness, SO WELL SAID. You are absolutely right on both counts. These are very hard things to talk about, so that it is easier to give the patient another pep talk about lowering his HA1C. AND they are so necessary, because as you so insightfully comment, if you don't get to the bottom of things, things will just keep going on the same dysfunctional track.

Comment #1

So here is the dilemma - the medical team feels an MRI is not medically indicated; the patient's wife feels it is a necessity. Where do you go from here?

Comment #2

This sounds like a very frustrating situations, both for patient and family and for Team D. Is there anything more you think might have been done so that patient and wife felt listened to?

Comment #3

This may have been racist behavior on the part of the patient and wife. Under very stressful circumstances, people's fear and distrust of "difference" often increases.

Comment #4

Unfortunately, this is a very good example of how difficult feelings in the care providers can lead to avoiding the patient, shorter time spent with the patient, less willingness to listen to the patient etc. All these things affect trust and care.

Comment #5

This is a wonderful metaphor. It makes so vivid the sense that patient/wife and medical team ended up on opposite sides.

Comment #6

Your insight about the deep trench and the difficulty of reaching out to hold hands was poignant and powerful. It captures perfectly what went wrong between the team and the patient and his wife. I think you are right that a different approach was needed. MRIs are expensive, but sometimes cost is not the most important consideration. On the other hand, maybe the "compromise" could have involved respectful listening, paraphrasing, and acknowledging. It's hard to look back and imagine what should have been done; but it is clear from your statement that the wife thought without her presence, no one would care for her husband properly. This is the fundamental underlying problem that needed to be addressed.

Comment #1

However you might choose to get this message across, to me it is the right message - very genuine and empathic.

Comment #2

Unfortunately, I'm sure you were right. The first thing sacrificed in a cross-language interpreted encounter is usually the "non-essentials" - the physician's friendly, personal comments.

Comment #3

Sweet and reassuring. You managed to create a human to human exchange, despite the obstacles. Given her history and traumas, ascertaining that she did not have SI at this time was also a good idea from a medical standpoint.

Comment #4

That is completely understandable. However, in the absence of urgent health issues, in my mind you made a good call. You actually managed to elicit quite an extensive history, and you broke through the language barrier and earned her trust. If you were to see this patient again, you laid a strong foundation on which to build a doctor-patient relationship.

Comment #5

I was impressed that you managed to connect with this patient, share a life AND determine that she was not suicidal. Cross-language encounters do take longer, if done properly. But we have to

remember that all patients, regardless of their language ability, deserve optimal care. I think you took an important first step in establishing that care - and hopefully her post-surgical pain were addressed by the attending and/or can be followed up with a subsequent visit.

Comment #1

I agree that this patient is an exemplar of a larger clinical dilemma - what is the significance of a patient asking for a particular drug, particular an addictive drug or a drug easily abused. In this case, the puzzle was to what extent was this medication justified; and to what extent was the patient "presenting" to the diagnosis, i.e., consciously manipulating her presentation to conform to criteria which would "produce" the drug she desired. You struggled with the challenge of determining whether this was "normal" college adjustment; ADD; or perhaps depression or some other problem. In such a case, the patient can contribute to the diagnosis, but should not drive it. I look forward to discussing this situation in class.

Comment #1

Hmm. He did say he'd "rather die." Why did he feel so strongly about the other hospital? Had he had a bad experience there? Did he feel he was being consigned to inferior treatment?

Comment #2

This is an excellent "diagnosis." I think what you're saying is that the pt felt excluded from the decision-making, and his only option was to refuse transfer. By listening to him, by connecting with him, by acknowledging his concerns, and trying to explain the medical perspective, you continued to try to persuade him in the direction of agreement with the treatment plan.

Comment #3

It sounds as though you did a terrific job in figuring out what went wrong with this encounter and trying to resolve it. It would have been a terrible outcome to discharge this pt home. It seems illogical, but when people feel a profound loss of control, they can act out in startling - and self-destructive - ways. Thank goodness you took the time to talk with the patient, to recognize his sense of disenfranchisement, and to let him know he was seen and heard. I hope you were indeed able to persuade him toward proper care.

Comment #1

It sounds like this is rather unusual behavior for the patient, which makes it especially frustrating, because unexpected - but also interesting. WHY is she acting like this?

Comment #2

It sounds like this is rather unusual behavior for the patient, which makes it especially frustrating, because unexpected - but also interesting. WHY is she acting like this?

Comment #3

It's sad but true that some people treat people they perceive as powerful much more nicely than they treat those whom they perceive to be lower on the hierarchy. This may have been a factor, but who knows.

Comment #4

There are no right answers. One thing you might consider in the future is making the covert, overt. "You seem a bit upset. Is there anything on your mind? Is there anything I can do to make you feel more comfortable?" That way the patient has to take responsibility for her behavior, while at the same time you might learn something important and/or be able to put her more at ease.

Comment #1

I wonder if she could verbalize more concrete what she was afraid of - cancer?

Comment #2

This is a good example of "acceding" to the patient's wishes while staying within standard of care.

Comment #3

This was a creative way of framing the situation - as a counterforce to her view that she is feeling fine, but the medications might make her sick.

Comment #4

Yes, this may be the underlying problem driving the patient's behavior. What is making her so anxious? Psych diagnosis? Life stressors? Traumatic history? Does she typically somatize her distress? This would be important to investigate in a follow-up visit.

Comment #5

In my view, you and the attending did well in assessing what you could (i.e. what the patient allowed) and agreeing on certain diagnostic work-ups. This likely conveyed to the patient that you are willing to hear her concerns and honor them - up to a point. Hopefully this beginning will build trust, so that in subsequent visits the attending will be able to tackle the issue of the patient's anxiety and lay groundwork for working as a team, rather than the patient demanding and the physician warding off these demands.

Comment #6

This sounds like a very difficult scenario, Thanh. I was especially struck by what the patient asked for and what she refused (breast and pelvic exams). She might just be uncomfortable with these exams as a new patient, but it might also indicate a history of some kind of sexual trauma. The patient was clearly testing you and the attending; and in my view you took the right approach in seeking compromise and common ground. Like you, I wondered about the patient's level of anxiety. This needs to be understood better to ultimately provide optimal care to this patient.

Comment #1

I wonder if it was possible for you to convey your own sense of heartbreak/empathy to the patient directly in a way she could understand.

Comment #2

Good catch on your part. This is certainly concerning, and shows you were trying hard to connect with your patient, despite the communication difficulty.

Comment #3

Excellent point. As you're probably aware, abuse is much higher in people with disabilities than in the general population.

Comment #4

Thank you for this awareness - this is indeed a difficult encounter for the provider; and how much more difficult for the patient!

Comment #5

What I particularly admired in your essay was your empathy for the patient's situation. She is grieving the loss of her mom, and simply acknowledging this (perhaps more than once) and expressing your sorrow is an important way of showing the patient you see her and hear her. It is indeed challenging

with patients who have communication challenges to figure out how to connect with them directly, rather than relying solely on the caregiver (who obviously plays a critical role in optimizing the patient's healthcare). Grief is universal and as you commented so well, is a matter of the heart. Recognizing and being present with the patient's grief would be an excellent start at developing relationship.

Comment #1

I wonder if it is that this patient "doesn't want" to help himself; or that he is so overwhelmed and frightened (underneath his belligerence and anger) that he doesn't know how. If this is the case, acknowledging the difficulty of the task in front of him while affirming your support may help him find a way forward (as the attending attempted to do). Admittedly, this is a long shot, but as you say, your job is to do the best you can.

Comment #2

You encountered an extremely difficult patient situation but there are lots of very similar patients out there. I think you got it exactly right - your job is to "do the best you can." You want to try to figure out what the patient is trying to tell you - maybe he is saying, it's not my fault I'm in this mess, I got terrible care in the hospital, no one is trying to help me. Maybe he's saying something different. The way to find out is to engage the patient in a conversation that is important to him -without acting unprofessionally (e.g., by saying Hoag is a terrible hospital) - but by validating his feelings and asking what he needs to help him get better. He sounds like someone no one listens to (understandably, because he is so antagonistic), so try listening before pursuing your agenda - getting the history.

Comment #1

Ouch, this does sound kind of rude. These situations are a hard call. If every patient in a hurry refused to talk to medical students, your learning would be compromised. On the other hand, sometimes the patient is really going to be inconvenienced, which you also want to avoid. Sometimes it's best to surface this issue: You might provide explanation that reduces the pt's anxiety and shows her the benefit to her - "Dr. F is with another pt, so this is not actually taking more time; and I can save you a little time by relaying certain information to him."

Comment #2

Excellent point. This patient, for example, might have wanted empathy about her concerns seeing a medical student; she might even have wanted a brief empathic statement about her cold. Mostly she wanted antibiotics, which might be a problem depending on the nature of the "cold." She clearly did not want a long interview - and this might be something to negotiate with her, and adjust your HPI accordingly.

Comment #3

I agree. You will not have the same relationship with the patient as their continuity physician does. However, you can establish trust even within a single encounter exactly as you say, by "reading" the patient, figuring out what their needs are and how some of these can be satisfied within the boundaries of good care. Often patients' biggest needs are to be seen, heard, and respected, even if they don't always get what they're asking for.

Comment #4

Thanks for posting - somehow I did not see it earlier.There is no question that being a medical student is an anomalous role - neither observer nor physician. It does put you in a sometimes awkward position. Mostly, as you say, patients are accommodating, but occasionally they resent the extra effort, which they perceive as not benefitting them. If you can point out any ways in which your interaction can support them, things sometimes go better. It is also true that even as a full-fledged physician you will encounter patients who are demanding, or fearful, or upset, and it is a good experience to learn how to work with these patients to develop trust and a sense that you are on their side.

Comment #1

Excellent observation. It is the "intangibles" of the doctor-patient relationship that are hardest to convey across language differences. Often the best tools you have at your disposal are nonverbal - a gaze, a touch, the tone of your voice. You can also ensure that your interpreter - in this case the daughter - actually translates your verbal expressions of concern and caring. These are frequently lost in translation as the interpreter decides it will save time not to bother to convey these sorts of statements.

Comment #2

I agree with your conclusion that connection between patient and doctor (or medical student) can be established through nonverbal cues. Your tone of voice, eye contact, body language, and use of touch really can effectively convey concern and caring. Often, when we do not share a common

language, we tend to pull back, exactly the wrong thing to do, as it leaves the patient feeling abandoned. Instead, as you did, we should persevere, try harder. Often, despite obstacles, as in your case, connection is made. Well done.

Comment #1

You know, this is the ongoing tension in clinical medicine - thoroughness/interest in patient story and efficiency/productivity. Neither "value" is inherently good or bad, but exclusive focus on one or the other will skew the nature of the healthcare system. IMHO, the system is already highly skewed toward efficiency at the expense of human connection.

Comment #2

You know, this is the ongoing tension in clinical medicine - thoroughness/interest in patient story and efficiency/productivity. Neither "value" is inherently good or bad, but exclusive focus on one or the other will skew the nature of the healthcare system. IMHO, the system is already highly skewed toward efficiency at the expense of human connection.

Comment #3

I'm reminded of a social science research study which found (astonishingly!) that interpreted interviews take twice as long as non-interpreted interviews. Thank goodness for social science since we no longer apparently have common sense :-). Yet language discordant interviews are not scheduled for more time. Again, efficiency triumphs.\

Comment #4

And again, I'm reminded of a Hmong folk saying - "You can miss a lot by sticking to the point." Maybe her tangents were important to her for some reason. This doesn't mean that efficiency should be sacrificed, but it should not be the only value. Sometimes people need time to build trust and show who they are.

Comment #1

You are always taught never to use family members as interpreters. Yet in this case, especially since the resident could understand Mandarin and could "monitor" the daughter's communications, it seems there might have been certain cultural benefits to the daughter stepping in for this very sensitive conversation. I wonder what you think.

Comment #2

Yes, pros and cons, and each situation needs to be weighed on its merits.

Comment #3

Excellent insight - members of different generations may view cultural norms differently and ask accordingly. It sounds from your description as though the team was able to strike a good balance between respect for traditional culture and encouraging everyone's voices to be heard.

Comment #4

This is a well-analyzed description of a critical family conference at the end of life. You had many valuable insights about the role of language and culture in making these difficult decisions, as well as the importance of paying attention to culturally-informed family dynamics. The result was a good resolution of a complex situation, one that respected cultural practices while striving to choose a course of action that provided the most appropriate care possible for the patient.

Comment #1

Your success with the earlier patient was admirable, and shows that it can be extremely beneficial for patients to share their stressors with their physicians. But timing is everything. In this case, even if you can "prove" to the patient that he is not having an MI, his expectations may not have caught up with this reality. Getting him to talk about his worries and feelings at this moment may not connect with his still-present fear that he is dying.

Comment #2

This is such an excellent insight, Winston. Even if we are on the right track, our attachment to doing what we think is right may blind us to how the patient is responding. Always be guided by the patient. If your tactic is not working, not matter how right it may be in the abstract, retrench and take a different approach.

Comment #3

You are so lucky to have grown up with this background - being sensitive to your own feelings and those of others will be of great help to you in navigating the "meta-text" of patient and family encounters.

Comment 4

Astutely observed. I really like the way you frame this as "differences in emotional cultures." Lovely. Everyone's feelings matter and deserve to be acknowledged - but how and when this is done varies greatly.

Comment #5

Well said - so not that your desire to understand the psychosocial context of this patient was in any way misplaced, but the mistake manner in which you approached these questions might not have been a good fit for your patient.

Comment #6

Exactly. You erred a bit in not starting where the patient was, but in trying to move him to where you (probably rightly so) thought he should be.

Comment #1

Yes, already we both recognize this is not a standard encounter: patient bearing gift, doctor rearranging schedule to accommodate, a personal escort from the waiting room! Is this pt. a VIP?

Comment #2

You were paying very careful attention to this interaction - great observation.

Comment #3

I wonder what your reaction was to this conclusion. Does it make you think about the pitfalls of treating family members?

Comment #4

As you know, expression of pain is partly cultural; but patients from many different backgrounds may accentuate their pain in order to convince the physician of the seriousness of their condition.

Comment #5

An excellent conclusion; and at the same time, it is always important to make allowance for individual differences within culture, i.e., the histrionic Japanese woman.

Comment #1

Good point. Not only patients have culture, but doctors have culture too - and it is the interaction that makes for a rich, interesting, and sometimes frustrating exchange.

Comment #2

Yes, I think most of the time patients really appreciate when the doctor (or MS) uses a word from the patient's language. Especially in these fraught times, it conveys respect and welcome.

Comment #3

Agree, this is the key. Respect is conveyed through interest and lack of assumptions and judgment.

Comment #4

Thank you for an interesting essay. I appreciated your sharing your perspective as someone not born in this country who has had to bridge two cultures. Your point about acknowledging the patient's language is well-taken. Your overall point that lack of respect for the patient and her culture can lead to misunderstandings and even avoidance of medical care is really important. Conversely, showing interesting, a willingness to learn, and a lack of judgment or assumptions can build trust and rapport.