***Introduction**: We are pleased to present the third in our series entitled "On Equity Story Slam". The following five essays were presented at the Department of Medicine Grand Rounds on January 11, 2023. The presentations were organized and coordinated by Lisa Skinner, MD, Keith Norris, MD, PhD, and Cristina Punzalan, Administrative Director. To review the recordings of "On Equity Story Slam", please visit DOM TV, where recordings of Medical Grand Rounds are accessible. The specific link for each individual presentation from January 11, 2023 is included at the end of each submission.*

## ON EQUITY STORY SLAM

# "A Breakdown in Continuity"

Olawale Amubieya, MD, PhD

This is a story from my time as a Pulmonary and Critical Care fellow working in the outpatient interstitial lung disease clinic. Around the same time, I had two new patients establish care with me. We will call them Mr. A and Mr. B. They presented in a remarkably similar fashion. Mr. A was in his early 50s and Mr. B was in his late 40s, so both young in the grand scheme of things. Both were Latino, and both had chronic hypersensitivity pneumonitis—the bad kind. The kind that doesn't remit or regress despite treatment. The kind that progresses relentlessly, leaving each man dyspneic and hypoxic. Over time, it became clear that each of them needed a lung transplant. Lucky for me, just like I am now, half of the ILD attendings then were also transplant pulmonologists. They would be easy referrals. Both men were young with single-organ dysfunction. Both were strong and ambulatory. Both had great social support. I never saw either of them at a clinic visit without their spouse or kids by their side.

There was one hiccup. Mr. A had private insurance, but Mr. B had MediCal. In all my time knowing him, there had been no problem with me seeing Mr. B in clinic. There had been no haggling over approval for CT scans, bloodwork, or PFTs—not an ounce of difficulty with his insurance in my clinic. But lung transplant evaluation and surgery here were nonstarters. UCLA's lung transplant program just didn't have the MediCal contract. More specifically, we did not have MediCal Center of Excellence status so we couldn't even begin to try to get the contracts. However, what that means and how it comes to be that the transplant center that does the most lung transplants in the Los Angeles metropolitan area doesn't have Center of Excellence status is a story for another day.

But that's enough right? Two patients in similar circumstances are forced to get differing care solely based on insurance, which is in turn based on socioeconomic status and resources. The outcomes don't matter here. This is not fair. On. Equity. We can end the story here, right?

Mr. A is referred internally, accepted, listed, and eventually gets his transplant here. For Mr. B, our UCLA transplant coordinator takes the time to put together a packet of records and send them to his counterpart at a local transplant center that has the MediCal contract. He gets his evaluation appointment in good time, has his testing, and is preliminarily determined to be an acceptable candidate. Now here is where things start to fall apart. Mr. B's chronic cough becomes intractable. So much so that it interferes with his eating, and he starts to lose weight, and his BMI drops too low. The transplant center warns him, that he must put weight back on or he will be removed from the waitlist. But he just can't. And he is delisted. Now, we tried. We tried cough suppressants and appetite stimulants. I sent him to the other program's emergency department to be admitted and given tube feeds to get his weight back up, but they sent him home. They said that wasn't an indication of inpatient admission. We even tried to arrange for him to get a G-tube placed as an outpatient, but before it could happen, I got the call from his wife, that he had died at home in his sleep. She said she was so thankful for everything we had one for him. I accepted her thanks and offered my condolences, but I was gutted. I went through the game of what-ifs. What if I had referred him earlier? What if they had admitted him when I sent him to the ED? What if I had been able to get him that G-tube faster? What if he had "better" insurance? But here is the real question: what if insurance didn't dictate care? Now I understand the macro argument, that Mr. B was not offered lesser services or even denied, he just had to seek them elsewhere. But that argument does not hold very well in the micro. It doesn't hold for Mr. B because he had to go from the place where he was receiving his care to a new system. He had to fragment his care in a way that left him open to falling through the cracks. Now, there are no guarantees that Mr. B would have fared better with different insurance.

Unfortunately, Mr. A's story doesn't end well either. He gets some good, very functional time after his transplant, but he eventually develops an incredibly rare plasma cell dyscrasia and passes away as well.

But like I said earlier, the outcomes aren't the point. This situation highlights the negative consequences of an insurance-based healthcare system that in its worst moments can function like a class system. It illustrates how that unequal system can lead to illogical decisions, like transferring care from the transplant center where he had received his pretransplant care to a different transplant center that holds the appropriate contracts for his insurance.

This story has a small silver lining. Our lung transplant program has seen this issue happen over and over again with different circumstances and different patients. And has now done something about it. They did the work and applied for Medicare Center of Excellence status. And we are now evaluating and transplanting MediCal patients. There are still some managed care programs for which UCLA is a nonstarter, but this is an important first step. One that all of us are very excited about. But until our society (and we at UCLA Health are society) values the lives of all Americans similarly and lives up to its proposed values of equity and justice for all, situations like these will continue. Whether it's the ability to perform surgery, follow a patient in specialty clinic, admit to inpatient psychiatry, or evaluate for a lung transplant.

*To view the recording of this story, which was presented at UCLA Department of Medicine Grand Rounds on January 11, 2023, please visit bit.ly/dramubieyastory.*

*Proceedings of UCLA Health*
*-VOLUME 27 (2023)-*

## ON EQUITY STORY SLAM

# "Grief"

Grace I. Chen, MD

Hmm. Still no cogwheeling or resting tremor but her tone seems increased and she can't seem to fully extend either of her elbows or knees on passive range of motion. I ask her daughter: "How is she doing with walking? Is she using a walker?" Her daughter replies: "Not really. She is not coordinated enough to use a walker anymore. She needs to hold onto someone when she walks. Most of the time she sits in her wheelchair and they wheel her around the facility."

Her daughter and I help the patient stand as I hoped to see the patient walk but she is unable to stand straight as she can no longer extend her knees past their flexion contracture point. She stands as if she is trying to half sit in the air. We help her sit back down and also sit ourselves.

I ask the daughter pointedly, "How are you doing?" There is a slight pause and she responds with, "Better actually. We seemed to have both reset after we both got COVID over Thanksgiving. Not being able to see her made me miss her. I am in a better place."

This time it was me who paused. I took a big breath in and held it for a couple of seconds before asking the daughter, "Do you want to hear about some of what to expect in the future with your mom?"

She looked at me with what seemed like a bit of surprise in her eyes and then said yes. We talked about her mother's flexion contractures, why she is getting them, sequelae of them and how to slow the progression of her being bedbound. She thanks me for taking the time to talk her through some of what to expect.

I think to myself about how both of them have changed in the past few years. The patient's dementia has certainly progressed. She has reverted to speaking mainly Mandarin, her first language, and her thoughts or conversations, if they start appropriately, quickly become non-sequiturs. Yet, she also seems less anxious and her face has filled back out from regaining her appetite and weight on mirtazapine. She is more child-like and appears content compared to before when she had more awareness of her declines.

Her daughter has changed, too. Not sure if it is due to acceptance or resignation or both. But at least the invisible heavy blanket of grief from watching her mom lose her vitality, function and self from both Alzheimer's disease and parkinsonism and her inability to stop it seemed to weigh less heavily today. Talking about the future seemed to be helpful rather than upsetting. We were conquering some of the fear of the unknown future together.

For some, the aging process is one of ongoing loss of independence and function. It maybe insidious rather than overt, but it is loss nonetheless and grief often accompanies loss. Grief is such a funny thing. It is not a linear process and it is not something that ever completes. It comes in waves. Some days the waves are bigger than others and some days the waves take different forms. And when you experience the grief of others, it can often remind you of your own.

It has been over 15 years since my brother died from a glioblastoma during my third year of internal medicine residency. Fascinating the memories and emotions that remain after so much time.

One of the most vivid memories was when he read me the findings of his brain MRI report. Apparently he had been experiencing diplopia for awhile and did not think anything of it as he thought it was due to being knocked around while playing basketball with our cousins. This was back before smartphones so he could not text me a screenshot of the report. He read the findings on the radiology imaging report to me word by word. He had no idea what he was saying as he said things like mass suspicious for glioblastoma and midline shift. But I did. Hot tears rolled down my face as he read because I knew in that moment that life as we had known was forever changed. He is dying; he will be dead soon. We will not grow old together. Of course, I didn't say any of this to him. I told him that I will figure out what to do and call back. Because that is what you do as the older sister and as the eldest child of an immigrant family, you are the language broker for your parents and you take care of things.

There are other vivid memories of that remaining year of his life. And there is one that never took place that also sits with me and that is one of the oncologist not addressing the elephant in the room with my brother and my mom after the tumor continued to grow and cause more mass effects despite the surgery, the radiation and the chemotherapy.

So, I continued my job as the language broker, only this time instead of translating English, I was translating what to expect to my family as my brother approached his end-of-life and what we should do. He passed quickly and peacefully at home on hospice.

As a society, we value youth and good health. We often marginalize the sick, the disabled and the old. We hope that by ignoring them, they fade from reality. And it is not any easier for us as physicians either. Most of us went into medicine to help people and it feels strange to not be able to fix the ailments presented to us. The grief from loss of function and independence that is often associated with debilitating medical conditions, terminal illnesses and/or aging is often emotionally charged, uncomfortable and inconvenient. While there are no goals directed medical therapy guidelines to fix the unfixable, we can wade into the uncomfortable waters with our patients and caregivers and hold space with them to name and acknowledge the losses and the grief. And sometimes holding that space helps that person grieving know that they are seen and acknowledged. And that they do not have to hold that grief alone.

*To view the recording of this story, which was presented at UCLA Department of Medicine Grand Rounds on January 11, 2023, please visit, https://bit.ly/drchenstory*

**ON EQUITY STORY SLAM**

# “The Power of Support”

Joshua Khalili, MD

Ali established care with me three years ago. He was 26 years old at the time, recently diagnosed with HIV in the context of gonorrhea and chlamydia infections and was struggling with methamphetamine use disorder, intermittently in outpatient rehab. I still remember pre-charting and seeing “not on HIV treatment/ART” in bold as part of his patient identification, as if it defined him. Ali was the first to say that he was in denial of his HIV diagnosis- he couldn’t bear to start treatment as it made the diagnosis a reality. Beyond a discussion of the importance of taking treatment and the fact that his health would likely be okay, the most important thing I knew that we had to talk about was his support system.

I learned that Ali was from Pakistan. Estranged from his father, he and his mother immigrated to the US when he was 10 years old. They struggled to find stable housing, but made it with the support of the community and other family members. Ali and his mother had a very strong bond having been through the trauma of immigration and housing instability together. She was the most important person to him in his life, but he worried that she didn’t know the real him as she didn’t know that he was gay, something that Ali was still reconciling and struggling to come to terms with. Despite having one friend who he could confide in, Ali felt frightened and alone in his understanding of himself and his new diagnosis.

Being part of a conservative, Pakistani, Muslim community, Ali feared that his mother and his other family members would disown him and never speak to him again. Something that unfortunately continues to remain a reality in many communities around the world and in the US. After a recent stay in rehabilitation for methamphetamine use, about one year after Ali established with me and learned of his diagnosis, he decided it was time that he came out to his mother about his sexuality and HIV diagnosis. He thought that it would be helpful to have me join a Zoom - which we were now doing so much more often in the setting of the pandemic - right after he told his mom, so I could help answer any questions and demonstrate my support.

I put my white coat on, tidied up my office background, I log into the Zoom appointment, and see Ali and his mom on the screen. As much as we learn the importance of staying in the moment with our patients and giving them our undivided attention, there are times when we are transported away and fall into the space of our own memories. When I saw Ali’s mother in the top right box on my computer screen, I immediately saw my mom in our house, 14 years ago, on a weekend home from college. She was chopping vegetables in the kitchen and my dad was at the dining table. This was the day that I would come out to my parents. After years of struggling with my identity, I had to tell them. My parents were immigrants as well, they moved to the US from Iran in 1979 among many other Jewish Iranians, maintaining elements of their culture that unfortunately were not open to LGBTQ individuals. Coming out to them was as challenging as what I prepared for. I didn’t get the “we love and support you no matter what” response that we would all hope for. My parents had to grieve the conceptions for the life they thought I would have and grapple with the centuries of discrimination established by cultural and societal norms in Iran.

Quickly, as I gathered myself and re-focused on being there with Ali and his mom, I could see the familiar pain in her eyes as I listened to him explain that he had always known that he was gay and this was something that wouldn’t change. He pleaded for her support as he reminded her that he was still her son and how much he valued their relationship. His mother turned to me, asking “Why did this happen to him? Does Ali have AIDS? Is he going to die?” I reinforced that while this was all difficult to process, he was doing well, and that higher levels of family acceptance can lead to decreased risks of mental health disorders and improved quality of life in LGBTQ individuals and her son. I encouraged her to support him, letting her know that people living with HIV live very healthy lives and that sticking to HIV treatment can lead to the same life expectancy as people without HIV, and that she played a critical role in helping him do that.

The video visit ends, I take a deep breath and move on to my next patient. When I return to my desk, I see that Ali sent a message, relieved to have come out to his mom and grateful for my support. Again, I escape my office and into a memory, but this time I’m a junior in college and just 2 floors below, seeing my primary care doctor, who happened to be a 3rd year UCLA Internal Medicine resident. I remember sitting on the exam room table and telling her, the first person I ever told, that I was gay. As she listened to my story she reached out her hand and I was overwhelmed by her support. In that moment I felt how powerful it is to just be there and listen to a patient in need.

Luckily for Ali and me, after many tears and time, our parents changed and learned to support us, understanding we were still the sons they loved. Ali has been doing quite well- he’s sober, adhering to his ART and lives with his mom in Denver.

Now, I think about the fact that in the past year almost one-half of LGBTQ youth seriously considered and one-third attempted suicide. LGBTQ adults are less likely to seek medical care as 1 out of 5 avoid doctor's offices because of discrimination. Through experiences with my parents, doctor and now my patients, I see how the ripples of support can impact many, and I'm empowered to stand by my patients and community to fight these inequities.

*To view the recording of this story, which was presented at UCLA Department of Medicine Grand Rounds on January 11, 2023, please visit* *https://bit.ly/drkhalilistory*

## ON EQUITY STORY SLAM

# “Patients, Politics, and Me”

Mina Ma, MD

*Thank you for asking me to be a part of this annual story slam which has always coincided with our celebration of Martin Luther King, Jr. and his dream of fighting injustice and oppression. You may know that Dr. King was also passionate about education and teaching one to think intensively and critically. Intelligence plus character –that is the goal of true education.*

Hi, I’m Mina Ma—M-A, that’s it! Short, easy, yet… easy name to make fun of. I’ve been called mini ma, maxi ma, Mina Massachusetts, and endearingly by my residents’ mama ma. What’s in a name? Identity, culture, history, and family. Ma is the Chinese word for horse. The Chinese calligraphy character looks like a rearing horse with its front legs in the air and its mane flowing in the wind. My dad was the youngest sibling, and the last hope to produce a boy to carry on the family name. As the firstborn, I was supposed to be that boy. Preference for sons in China has long been based on a patriarchic society in which sons were preferred because of the belief that males can earn more than females, and daughters no longer have responsibility for their parents once they marry. Thus, when my parents had a second daughter, it fell upon me as the oldest to shadow my dad, who taught me to mow the lawn, change the oil on a car, and read the financial pages. Thus, when I got married during medical school to a non-Chinese, there was no question that I would keep my name. 1) I didn’t want to go through the hassle of completing paperwork to change it, 2) I wanted to honor my dad, and 3) more importantly as a physician, I didn’t want to be listed on any health insurance network with an Anglo name and have a patient show up in the office and be surprised at my cultural identity.

Although in some ways, it’s surprising that I wanted to keep this name because mostly I remember being teased because of it, teased about my family’s ethnicity. As immigrants to this country, my parents tried hard to assimilate but were often subject to overt discrimination and micro-aggressions. My dad would be angry when this occurred and would speak up when he perceived he wasn’t being treated properly, albeit with a very heavy Chinese accent, which usually made things worse. As a child, I didn’t see this as someone standing up for his rights, instead, my sister and I would embarrassingly cower in the corner and try to become invisible, whether it be hiding in the clothes racks at a department store, or walking away as if we weren’t associated with him. As we got older, we even went so far as trying to convince him to stop causing a scene, and telling him maybe he was wrong.

It was during these moments unbeknownst to me, I was learning about speaking up and helping others, although it would be many years before I felt comfortable doing so. There was always the fear of bringing more attention to myself, that I was not white, and maybe I didn’t belong here. When I became a physician, the respect for the hard work and grueling training, finally helped me feel that I belonged, and then it was more natural for me to speak up, although I still find it easier to speak up for others than for myself. It’s a true privilege to be able to do this for our patients.

However, my patients sometimes test me and I often wish to call out some of the things they say. For example, it is not uncommon for a patient to ask me “where I’m from”. I’m sure they are just curious and well-meaning, but it brings up those feelings of not belonging, of not fitting in, that stem from childhood taunts. If I’m generous, I will tell them that my parents were born in China before leaving for Taiwan, and then immigrating to the United States. When I’m less generous, I tell them that I was born in Texas (yes, Texas) and grew up in the Bay Area.

Then there are the patients who have become more outspoken about politics in the past decade. One of my patients is a soft-spoken intellectual man who has had metastatic melanoma, prostate cancer, and more recently esophageal cancer. As a retired chemist, he would present thoughts about his treatments while simultaneously musing about the politics regarding immigration. I often wondered if he thought I agreed with his comments because as physicians we have been taught that “doctors provide care to patients, regardless of each side’s political beliefs” and I would bite my tongue and simply nod. In fact, while we are not strictly prohibited from discussing political views, the AMA’s Code of Medical Ethics states physicians should “refrain from initiating political conversations during the clinical encounter” and that “physicians must not allow differences with the patient or family about political matter interfere with the delivery of professional care.” In essence, the exam room should be off-limits from political discussions.

Another patient of mine, a middle-aged redhead, really made me question this stance of saying nothing, as I repeatedly endured her off-color remarks in the exam room as she digressed about her love life or lack thereof intermixed with politics. Was I being complicit in my silence, or passively endorsing what she was saying because I was afraid of controversy? However, on the last visit that I had with her, she was frustrated with a mishap at check-in and insulted our front office staff with a racial slur. She disparaged them to their face and repeated her comments to me. This time rather than deflect, or avoid a conversation about racism and discrimination, I calmly told her that she could no longer be cared for in our office. While she was shocked at the dismissal, I was equally surprised as I typically would have just endured her assault if it had just been directed at me, but as she had directed it at our staff, she had clearly crossed a line and I knew at that moment that I had to intervene. Speaking up and helping others is our job, especially for those that have been marginalized.

It hasn't been easy because of our long-engrained teaching to remain apolitical, to find out what's going on, and to give someone the benefit of the doubt. It has been even harder to know how to navigate this over the last decade as we have seen politics seep into the exam room. Yet, I'm encouraged, as I see this in our young doctors today, they are using their voices to make changes, especially in the area of health disparities. We are human too and need to express our feelings as well. This politicization of health care seemed to have started with the Affordable Care Act and then really escalated in the last few years with the COVID pandemic. Doctors have now felt the need to be a part of the conversation, to stand up for science, and to speak up for our public health leaders. We now know we can play a crucial role in shaping the future of healthcare, and if we don't speak up for ourselves and our patients, others might do it for us. **Yet it is still our duty to grapple with where to draw this line so that we don't harm the credibility we hold in this privileged position of being a physician.**

So as physician educators, instead of avoiding the topics of political and ethnic bias, we need to train physicians on understanding how to handle these situations when they come up. So perhaps there is a place for politics in the exam room, or at least in medical education. If my dad were still here today, he would know that I am no longer hiding in the clothes racks and that I didn't miss his lessons of standing up for what's right, just as he did many years ago.

*To view the recording of this story, which was presented at UCLA Department of Medicine Grand Rounds on January 11, 2023, please visit [https://bit.ly/drmastory](https://bit.ly/drmastory)*

## ON EQUITY STORY SLAM

# "Peace Be With You"

Carlos Oronce, MD, MPH

I meet with the team for rounds the morning after a call day at the West Los Angeles VA. I glance at the list and it doesn't look bad at all. A few patients admitted for placement. I'm a new attending and always feel a little relieved when I see that because it's often a straightforward hospital course. We would order PT/OT, place a referral for a nursing home, and send the patient on their way in a few days.

Our team starts to tell me about a patient admitted for placement, who I'll call Mr. Larry. He is a 70-year-old man with a history of substance use disorder. He uses cocaine and is on buprenorphine for his heroin use disorder which has been in remission for a few years. He also has really bad arthritis of the hip which limits his movement, and he uses a rolling walker for assistance.

But as I'm skimming Mr. Larry's chart and listening to the resident present, I get the feeling that this won't be so easy. I have a growing unease because of the terms and language others have used to describe him like, "patient does not engage in care, patient has a pattern of signing out of the hospital and skilled nursing facilities against medical advice or AMA, he refuses to care for self," and of course, cringe-worthy direct quotes of the patient yelling at staff.

The team informs me that he was admitted for placement because the residential treatment facility where he was could not care for him because he was unable to perform his activities of daily living; our clinical vocabulary for feeding, dressing and grooming one's self. In the social history, it's also noted that he's unhoused.

I went and saw Mr. Larry on my own without the rest of the team. He was walking around the nurses' station with his rolling walker, a short shuffled gait, and a slightly forward hunch to his posture. His face was weathered, appearing older than his 70 years. To my surprise, I noticed several bags of chips and Mountain Dews at his bedside table and had a light chuckle. The nurses told me he left the unit to the vending machines downstairs and I'm just glad that this frail-appearing older man made it back without falling. He smiled at me as I introduced myself. He stared at my badge for a while and curtly said he couldn't pronounce my name so he would call me Dr. Carlos. Like so many of our VA patients there was a certain charm to his demeanor and said that was okay with me. Then, I explained the plan. We would have our physical and occupational therapists evaluate him, and would try to find him a nursing home where he could regain some strength and function so he could live on his own.

As predicted, placement was difficult because of his prior history of AMAs, which was frustrating. No SNF wanted to offer a bed and no other residential treatment facility was going to accept him unless he was independent with his ADLs so we were stuck in dispo limbo. Every day felt like Groundhog Day, repeating the plan, examining him, but also learning more about him each day. I learned he was in the Army. He enlisted voluntarily and turned down a college baseball scholarship. I learned he had PTSD from his time in Vietnam. He once solemnly told me, "Dr. Carlos, they took us all away from our moms and sent us to another land where we killed their moms." I learned that he lived in south LA his whole life, loved his family, and wanted to write a memoir one day. Once I asked about his spiritual beliefs because there was a book of Psalms on his bedside table. I learned he converted to Islam a few years before and picked up some Arabic. I said, "*Assalamu alaikum*," the only Arabic I knew which is the traditional greeting of, "peace be upon you". He reciprocated with, "*wa-alaikum salaam*," There was clearly more to Mr. Larry than what was reflected in the chart.

Another day went by and we finally received a bed offer. As things sometimes happen in the hospital, a dispo plan came together unexpectedly and rather quickly. The team dutifully collected his discharge paperwork and med rec. When I approached him with what I thought was good news, he was furious and turned down the offer. "Dr. Carlos, it's too soon, I need to get some affairs in order." I had no idea what he was talking about. He contacted his VA housing social worker, who recognized the importance of the situation in getting him to more permanent housing and urged him to accept the offer but he was insistent.

The following day, staff were understandably frustrated because he was off the unit for several hours. The nursing home coordinator requested a urine drug screen on behalf of a nursing home that was considering a bed offer. The drug test was positive for cocaine. At this point, I was having a lot of mixed feelings. Disappointment and guilt. Frustration because I wish he just accepted the bed. Anger at a system that had us order an unnecessary test that didn't benefit him and only stigmatized him.

When I informed him, he erupted. He told me he felt like he was incarcerated, that he felt like a criminal looked at with suspicion. He pointed to a brand new rolling walker at his bedside and said he was off the unit at prosthetics. He yelled out emphatically that he was a Black man who served his country honorably, saw terrible things, and came home to America only to be discriminated against and mistreated. He shook his cane at me in frustration and said, “I’m a man. Talk to me like one.” I could only nod in acknowledgment.

As he’s talking, I’m recognizing that despite his frailty, age, experiences of racism, substance use, Vietnam vet status, and homelessness he’s survived and thrived in many ways and has had this beautiful life. He’s angry because he just wants to exercise some control over his life. And he’s an individual with all of these life experiences that have shaped him and those experiences should be able to shape how we care for him too.

He did not receive any other bed offers for the rest of my time there. On my last day, I was disappointed to share with him that again there was no bed offer and I was rotating off service. As I left the room he said, “Thank you for listening, Dr. Carlos. Peace be with you.” And at that moment I felt guilty because I was so focused on him as a placement patient, just trying to get him out the door before the next attending came on. I didn’t appreciate him fully as the complicated human being he is, with his hopes, goals, and dreams for the future. I think maybe if I spent more time with him, got to know him sooner, and saw him not as a difficult dispo, but as a person maybe we’d have a better outcome. Maybe if all of us in health care paused and spent more time with our patients we’d have a better system that could care for and support people like Mr. Larry.

*To view the recording of this story, which was presented at UCLA Department of Medicine Grand Rounds on January 11, 2023, please visit [https://bit.ly/droroncestory](https://bit.ly/droroncestory).*