We are careful to remind students of the need to sustain high levels of professional behavior when working with frail elderly patients. In particular, we emphasize the need for confidentiality and tact when interviewing residents of a long-term care center. These patients thoroughly enjoy student visits but are liable to say things that could be embarrassing to themselves or their families if not kept confidential. We remind the students that they could be interviewing a grandparent of a friend or classmate and to respect the dignity and privacy of the patient. Unfortunately, in our zeal to ensure appropriate tact on the part of the students, we overlook the possibility of “unprofessional behavior” from the patients.

Students know that obtaining appropriate clinical data from a cognitively frail patient is an essential skill, and they consistently rise to the challenge of these unpredictable interviews. They know that patients often make comments they would never have made before dementia robbed them of their full capacities. Students usually successfully deflect comments about their youthful appearance or style of dress. Sometimes, however, patients make comments that would be unacceptable in any other context. For example, patients may make disparaging remarks about persons of color, or those who have unfamiliar accents, or even members of specific religious groups. Comments can also be exquisitely personal. In one memorable episode, a shy young man from a small rural county was left alone to interview an energetic and garrulous 92-year-old lady who had mild dementia. She fixed on his surname and immediately identified that he came from a specific small town. After a few questions to establish his pedigree, she treated him to a long, detailed, and scandalous description of his grandmother’s social life and sexual indiscretions during World War II.

These situations raise several concerns for teachers. At a basic level, should we as caring clinicians expose our patients’ lapses in judgment and social graces to our students? Most patients thoroughly enjoy student visits and actively compete for the “young doctors,” but careful selection of teaching patients is crucial and can be difficult. I spend much more time placating nursing home residents who have not had a student visit than I do trying to persuade patients to participate. I regularly have to resolve disputes between patients over who will get to see students. Participation in teaching is obviously therapeutic for patients. They rise to the occasion and are not troubled by any indiscretions they commit. For many patients, helping the students is one way to make some meaning out of their health problems or as one man expressed it, “to get one back at that Alzheimers!”

Teaching activities raise group and staff morale through the message that “This facility is so good that the university sends its students here.” Family members have been universally supportive of their relatives participating in teaching. They also see teaching as a validation of the quality of care and find comfort in the ability of their frail elders to make a positive contribution to medical education. Although I routinely ask family members’ permission for teaching, I have yet to have anyone ask about professional confidentiality or refuse participation.

Conversely, although educators must prepare students to handle inappropriate language and behavior from patients, surely we have some responsibility to protect our learners from insults and embarrassing situations. Spending too much time before the encounters on anticipatory guidance for the students cuts into precious patient contact time and can make some students even more nervous about an already stressful exercise. But, being immediately available for feedback and group debriefing is essential. I try to listen in on interviews without being observed, but this is often not possible.

Some of the best learning has happened when a patient has started giving me a hard time in front of the students. Students have been treated to unfavorable commentaries about my abilities to fix medi-
cal problems, my appearance, my Scottish accent, and especially my sense of humor. The students enjoy this, and it provides a bridge to discuss how to handle challenging situations.

I suppose it all comes down to carefully selecting the patients for teaching, preparing the students, and remaining vigilant for the teaching moments. Although patient indiscretions can be uncomfortable, they have opened up many frank and profound discussions about practicing medicine and caring for patients even under personally challenging circumstances. Discussing “what do you do when…?” and “the stuff that is not in the books” immediately after a challenging patient interview is powerful and enjoyable teaching.

The great advantage of having such discussions about challenging elderly patients is that in other contexts the “challenging patient” is easily equated with the “deviant” or “nasty” patient. Working with sweet old ladies who do “bad” things helps the students realize they have a responsibility to manage the situation and not to walk away or refuse to deal with patients who “behave badly.” My biggest concern, though, is for the quiet students who do not reveal their discomfort or bad experience and never develop the skills to manage uncomfortable patient encounters. By progressively isolating themselves from potentially hurtful situations, such students miss some of the most rewarding (but never easy) aspects of practicing medicine—as someone once said, “No sailor ever distinguished himself on a tranquil sea.” More importantly, these students ultimately deny their care to some of the most vulnerable and needy of patients. Regardless of age or medical conditions, those patients who challenge us with “unprofessional behavior” are likely to be those with the greatest needs.

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