HANDOFFS

Postcards from Our Students—Reflections on Professionalism and Ethics

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During their junior medicine rotation, our students are asked to post to Blackboard (an online student forum) an anonymous essay about an issue of professionalism or ethics, either inspiring or troubling. In many ways, these vignettes are like postcards, written by visitors describing foreign cultures and norms. They represent a way for the students to debrief, but also provide an opportunity for us, as faculty, to reflect upon the way we practice and teach medicine. Many postings—like postcards from exotic or historic places—are inspiring stories of residents and faculty extending themselves for their patients. Unfortunately, unlike typical postcards, there are also essays that are troubling or provoking and challenge us to consider how we could improve the professional and ethical environment on our teams.

In order to begin a learning process with our faculty and housestaff, we have presented a number of these anonymous essays at both faculty and housestaff Department of Medicine conferences as well as our monthly hospital Ethics conference. The goal of these conferences was to gather as a moral community to reflect on our students' experience and consider ways in which our day to day practice as attendings could be informed by what they tell us. In addition, the junior medicine site directors have a session each quarter with their junior students to review some of the most significant issues brought up by their essays.

Practically, these vignettes and conferences serve three main purposes:

1. Raising Awareness: Many professional issues noted by our students occur "under the radar". Attendings are often unaware of the issues of professionalism and/or ethics confronting our students and housestaff.
2. Exploring Attitudes: Some attending may underemphasize the importance of specific issues of professionalism and/or ethics. Open discussions at faculty or resident conferences create opportunities for individuals to reflect upon their own reactions and for the group to create a "norm".
3. Sharing Skills: It is difficult to learn the practice of professionalism and ethics from a book. Skill in this area is gained primarily by experience. Conferences provide an excellent forum for seasoned physicians to share wisdom with less experienced physicians. In addition, important

teaching points can be made: "Students should not deliver bad news alone." "Errors should be disclosed."

Following are 3 of the essays we presented, along with brief commentaries. At the end, we provide practical suggestions for individual attendings to improve the professional climate on their teams.

The Hospital Didn't Wait

Code. On 12, the surgical wards floor. Elise sprinted to the stairwell, dashed up to 12, and ran to the corner room as fast as she could. She could see the room before she got there. Instinctively, she started reviewing the steps she had memorized so many months ago. But when she finally arrived at the patient's bathroom, her thought process came to a jolting halt as she came upon the gruesome scene.

The 76-year-old patient had hanged himself with the cinching rope from his garment bag, and now dangled suspended from a high towel rack against the wall. Nurses from the floor started to file in, and without losing a beat Elise barked commands. Together they brought the man's body down to the floor, laid him on his back, and stripped off his hospital gown. Elise was in charge; deliberately but forcefully, she ordered a nurse to retrieve a defibrillator, and had another resident check for a pulse. There was none. Anesthesiology was here. Quickly and expertly, they shoved a plastic tube down his throat and began ventilation. The nurse placed on the electrodes between chest compressions then called to clear the body. Airway stepped back. The chest pumper stepped back. The body lurched forward as the defibrillator issued a long beep and discharged. Still no pulse. The cycle repeated.

Finally, Elise called a stop. Time of death, 19:37. By now there were about 20 people crammed in the patient room, all of whom had a separate role during the code. Some stayed behind, while the rest left to return to their interrupted work. The medical student didn't know what to think as he returned to the team room. His jaw was sore—had he been clenching it the whole time?—and as he brought his hand up to rub his face, he saw that his knuckles were bloody. Somehow he had scraped them during the code. As he logged back into the computer to finish off his evening notes, he knew that he wouldn't have time to reflect until hours later when

he returned home. Codes happened all the time. There was still work to be done in the hospital, and the hospital didn't wait.

The room had already been assigned to a patient waiting in the Emergency Department downstairs. That patient would be here in a few minutes. The hospital didn't wait.

When we presented this case in our conferences, there was universal agreement that such a traumatic event merits, even demands, team debriefing and processing. But in the real life aftermath of this traumatic event, the take-home message for the medical student was that "the hospital didn't wait" for such discussions. We know this is not unique to our institution. In a study of 32 medical students who were asked to reflect on their most memorable patient death,[1] debriefing sessions were rare and many students felt inadequately supported. While experienced clinicians may be accustomed to seeing patients die, students are new to the culture of the hospital, and have not had the chance to develop the defense mechanisms necessary to cope with this sort of experience. Angoff[2] writes, "As medical educators, we ought to ask our students how they are coping with long hours, fatigue, illness, suffering, and death. We ought to model and commend compassion and react to the deep feelings of our students in the same way we would teach them to react to the deep feelings of their patients."

''I Told a Man Today That He Had Brain Cancer''

The resident, intern, and I were huddled together in our team room when the report came back on the computer. "New 3.5 × 2.3 × 1.7 cm contrast-enhancing lesion seen anterior to genu of corpus callosum. Concerning for metastatic focus vs. lymphoma. Advise follow-up." It wasn't unexpected … but we had nevertheless been hoping for better.

The three of us went into his room and I was waiting to see how my resident would deliver the bad news, but she didn't. She simply said that we were continuing to do imaging studies and that a neurology team would be in touch. There were probably several reasons why she didn't tell him: not enough time, not her responsibility, or maybe she was just uncomfortable with it. Whatever the case, we left the room with my patient still oblivious to the awful mass now tangled in his head.

If my resident was taking a pass on this conversation, I knew it fell to me … he needed to hear it from his primary team. I came back after rounds alone, sat down next to his bed, and told him that his MRI results had come back, and that I had unfortunate news.

I told him that the images showed that his lung cancer had spread to his brain.

I paused to give him a chance to let it sink in. He turned away and looked up at the ceiling.

"Where is it? How big is it?"

"What now?"

Reflecting on this case, our audiences were disturbed that a student would attempt this difficult conversation alone, while recognizing that the student clearly felt a sense of responsibility and desire to help his patient by sharing important information. We talked about how students may erroneously pick up a message that the team member who has "spent the most time with a patient" is the most obvious choice to have difficult conversations. We also noted that, unfortunately, sometimes students are directly asked by their team to shoulder this responsibility on their own. In this painful account, there is no mention of preparation, supervision, or support for the student before or after the encounter. The student perceived (rightly or wrongly) that the team leaders lacked comfort or skill to deliver the bad news, and stepped in. It is possible that the attending lacked the skill and ability to model an interaction, but more likely the deficit was in awareness and attitude. It is unlikely the attending knew that the student had this conversation alone. One of the major reasons we present these vignettes is to make attendings and housestaff more aware of issues that occur under their radar so that they can take preventative action. However, once the resident or attending found out that the student had this conversation alone, the student should be pulled aside for a 1:1 discussion. At the end of the day, the student should know that it was inappropriate to attempt this conversation alone

Rosenbaum[3] reviewed a number of strategies to teach the skill of delivering bad news, from lecture and small group discussions to role play and standardized patients. When asked, students cited role-modeling as the best way to learn how to deliver bad news.[4] Observation of a veteran clinician provides a firm foundation for learning; but that is not enough. Unfortunately, we know from the literature (and our student vignettes suggest) that students and residents are unprepared to carry out these conversations properly, either because of misguided attitudes, lack of experience, or inadequate training.[5–7] We conceptualize engaging in difficult conversations as a procedure, demanding a skill set. Mere observation of an expert executing this procedure is only a beginning. With any other skill, from successful completion of a lumbar puncture to initiating cardiopulmonary resuscitation (CPR), a student would never conclude that "knowing the patient the best" sufficiently credentials the student to undertake these procedures. We maintain that a difficult conversation—be it breaking bad news, discussing end-of-life care preferences, code status discussions, or prognosis—is a clinical intervention, like any other "procedure" in medicine. If performed with skill and caution, it can bring about a stronger therapeutic relationship and increased support for the patient; if performed clumsily, it can lead to unintended adverse outcomes, including misunderstanding, mistrust, anxiety, and anger.

''A Decimal Point Got Misplaced''

On palliative care, I had a 90 year-old man with end stage lung CA that presented to the ED with increasing SOB. The resident decided that giving him some morphine would be a

TABLE 1. Examples of Attending Behavior that Fosters an Ethical Climate

Attending Activity	Examples
Creating an Open Climate	
Breaking Communication Barriers	Setting aside time for introductions and "team building" exercises at the beginning of a rotation, with attending participating equally with residents and students
	Emphasizing attending availability to discuss or review problems of any kind
Setting Clear Expectations	Emphasizing the importance of patient-clinician or family-clinician communication from the outset
	Devoting some attending rounds to "Difficult Conversations" (e.g., breaking bad news or code status discussions)
	Explicitly stating that "no ethical question is a stupid question" and providing positive feedback for raising such questions for the team
Regular "Check-ins"	Establishing team "communication rounds": 10 minutes every day to review a good, bad, or awkward interaction from the past day (e.g., family meeting, DNR discussion)
	Setting aside time on rounds or during attending teaching sessions to explore the team's or an individual's emotional responses to a patient's death or deterioration
	Writing exercises that focus on our reactions to challenging situations that are shared with the group
Supervision and Modeling	
Planning	Clarifying an agenda and practicing key phrases for a family meeting with the resident prior to meeting the family
	Anticipating which patients may require a code status discussion and discussing a "game plan" on rounds
Modeling	Students observe the attending facilitate a family meeting
	Residents observe the attending apologizing for an error, no matter how small
	Attending thinks about an interpersonal conflict "out loud" and models asking patient-relations for help
Debriefing	Reviewing a family meeting with and giving feedback to the resident who facilitated
	Reviewing a challenging code status discussion as a team

good solution but was worried that too much would push him over the edge. He was thin; his O2 sats weren't that good ... After some discussion it was decided that 2.5 mg should be the starting amount. Unfortunately, when the note was written a decimal point got misplaced and he got 25 mg as a first dose. He ended up very sedated for most of the day but his breathing was ok.

The mistake was not discussed with the patient or the patient's family. While it did not cause any lasting harm, I wondered if telling the patient/patient's family that an error had been made would have been more ethically sound.

When we presented this case in our conferences, there was little controversy about whether the error should have been disclosed. The discussion did provide reinforcement for doing a simple but difficult task. Our analysis is that the nondiscussion of this error reflects a deficit in attitude and possibly skill. The team was aware of the error, but the resident and attending did not take the opportunity to disclose an error. They should have. We do not know whether the attending or resident felt unprepared to discuss this or were simply unimpressed with the adverse event. We do get the sense that the student did not feel comfortable raising the issue with the team. As such, it was a missed opportunity to seek help from any number of hospital resources and find encouragement to take on difficult encounters.

Much has been written about apologies.[8–10] Disclosing errors and apologizing is the ethical standard, and many of our institutions have made it policy. Yet in the moment, it is embarrassing, anxiety provoking, and our concern about litigation looms large. Learning to do the right thing begins, perhaps with lectures and standardized patients, but only when students see it modeled by our housestaff and faculty, does it take root for good.

Our housestaff are quite good at managing medical issues, but they may still need help in creating the appropriate environment for professional learning and growth. This is 1 of the most important contributions an attending can make. We have emphasized that faculty have an important role to play in the area of professional development, reinforcing the rudimentary information preclinical students are presented with in the classroom and processing experiences residents are exposed to on a regular basis. If the hospital "doesn't wait", then it is the attending physician's job to create the space and time for trainees to think about what is happening and ask if it could have been done better.

A number of seasoned clinical teachers have written about ways to improve teaching on the wards.[11] Below, we will add to that discussion by considering practical ways to enhance learning about professionalism and ethics (see Table 1). Note should be made that while we focus on specific behaviors and activities, underlying all is the importance of availability, presence, and intention. Like all good teaching, these activities require planning and effort.

Creating an Open Climate

The medical team, of which the attending, residents, and students are all a part, should not only be a unit that provides excellent medical care to its patients, but should also create a culture of continuous learning and improvement. As such, it is important to create a safe atmosphere where teachers are invested in the growth of their learners and learners feel free to question the prevailing logic and practice, including issues of professionalism and ethics. As Malcolm Gladwell[12] describes in *Outliers*, Korean Air jets were crashing because subordinates were afraid to question their superiors. Once that culture changed, Korean Air safety

improved dramatically. Similarly, breaking down some of the hierarchical barriers should improve the culture of a medical team. We typically make an effort to get to know our students and residents on a more personal basis: where they are from, who is in their family, what was their major, what are their interests outside of medicine, and what has been surprising to them in their training so far. Whether we set aside time when we first meet or e-mail our questions before the first day, we aim for this to be 1 of the first "team" activities. We also share our own stories, making clear that the attending is part of the team, and not just an evaluating supervisor.

Vignette 1 describes the student's trauma of witnessing a code and the inability to process the event with anyone afterward. Failed resuscitation attempts are the most dramatic examples, but even expected deaths, nonfatal adverse events, and conflict between patients and providers may be traumatic for new trainees inexperienced with the "reality" of medicine. Attendings should be aware of these potentially traumatic events and make time to check in with the team members about how they are dealing with their emotions. Taking time on attending rounds, for example, allows the attending to not only model reflective practice and self-care, but also elevates team support to a place traditionally reserved for discussions about diagnosis and treatment.

Supervision and Modeling

Vignettes 2 and 3 center around challenging communication tasks that require special training, including instruction, modeling, feedback, and practice. Unfortunately, as some of our student accounts document, many teaching opportunities are missed. As attendings, our duties include being aware of these opportunities, and being prepared to model competent patient—or family—doctor interactions. Emphasizing the importance of the doctor-patient relationship is in fact one of the key skills of an effective attending role model.[13]

When opportunities arise for any potentially difficult conversation, we make every effort to identify the issue, "prebrief" with the team about how to conduct the discussion, and either offer to model the conversation or be present to observe and provide feedback and "debriefing" afterwards. For example, by asking about all DNR discussions had with our patients, we gain insight into the skill level of our housestaff. As important, the housestaff understand that we believe that these conversations are vital to review during formal rounds, with the same attention we give to chest pain and electrocardiograms (ECGs).

Two key skills that develop with experience are the ability to know the limits of one's knowledge and to know when to ask for help. We try to be open about naming those limits and thinking about the other members of the larger healthcare team that may provide insight, skill, and expertise. We are used to doing this with "medical" questions (eg, asking the gastroenterology consult team to locate a source of bleeding). Asking our risk management, patient-relations, or ethics services to assist with a difficult communication task

or conflict with a family is no different, and often something the housestaff may not readily do.

We are grateful to our students and their "postcards" for the snapshots of our local medical culture. While we are gratified to read of excellent role modeling, we are also disappointed to read of situations which have left our students confused, demoralized and cynical. But if these exercises are to reach their full potential, they should tell us about where we would like to go, in addition to where we have been. We believe that our conferences have stimulated our faculty and housestaff to reflect on the professionalism lessons they are "teaching". Reading the student postings has definitely affected our approach to teaching professionalism. They reinforce what every parent and educator knows: when it comes to teaching professionalism, communication and ethics, what matters most is the behavior of the teacher. Our words mean little if our actions do not live out what we espouse.

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References
1. Rhodes-Kropf DJ. This is just too awful; I just can't believe I experienced that. *Acad Med.* 2005;80(7):634–640.
2. Angoff NR. A piece of my mind. *JAMA.* 2001;286(9):1017–1018.
3. Rosenbaum ME. Teaching medical students and residents skills for delivering bad news: a review of strategies. *Acad Med.* 2004;79(2):107–117.
4. Ratanawongsa N. Third-year medical students' experiences with dying patients during the internal medicine clerkship: a qualitative study of the informal curriculum. *Acad Med.* 2005;80(7):641–647.
5. Tulsky JA, Chesney MA, Lo B. How do medical residents discuss resuscitation with patients? Official journal of the Society for Research and Education in Primary Care Internal Medicine. *J Gen Intern Med.* 1995;10(8):436–442.
6. Tulsky JA, Chesney MA, Lo B. See one, do one, teach one? House staff experience discussing do-not-resuscitate orders. *Arch Intern Med.* 1996;156(12):1285–1289.
7. Gorman TE, Ahern SP, Wiseman J, Skrobik Y. Residents' end-of-life decision making with adult hospitalized patients: a review of the literature. *Acad Med.*2005:80(7)622–633.
8. Pelt JL. Physician error and disclosure. *Clin Obstet Gynecol.* 2008;51(4):700–708.
9. Murphy JG. Revealing medical errors to your patients. *Chest.* 2009;133:1064–1065.
10. Lazare A. Apology in medical practice. *JAMA.* 2006;296:1401–1404.
11. Ende J. What if Osler were one of us? Inpatient teaching today. *J Gen Intern Med.* 1997;12(Suppl 2):S41–S48.
12. Malcolm Gladwell. *Outliers.* New York: Little, Brown, Co., 2008: p. 177–223.
13. Wright SM, Kern DE, Kolodner K, Howard DM, Brancati FL. Attributes of excellent attending-physician role models. *N Engl J Med.* 1998;339(27):1986–1993.