SUMMARY ART OF DOCTORING GROUP 1 12/16/03

Group was in a festive mood. A contributed gingerbread people, and B contributed a pirate joke (!). A briefly presented a proposed model for dealing with difficult or challenging situations, either between students and supervisors or between student-physicians and patients. There was limited discussion, but we did discuss the feasibility of the model due to time constraints. A noted that practicing the steps made the process more automatic, and therefore swifter. Students presented various clinical problematic clinical scenarios.

C described a situation in which an older attending chose to rely on his own experience, which was in conflict with the latest EBM recommendations, in when and how to remove a breathing tube. The chief resident protested, but the attending went ahead with his plan. The student said nothing, but was concerned and felt this type of event occurred with some regularity on the wards. We discussed possible goals for patient, attending, and student (intention). Some goals mentioned for patient were 1) to have a good outcome 2) to receive standard of care; for attending 1) to become more knowledgeable 3) to become more comfortable with EBM guidelines. No goals for students were mentioned, but indirectly there was some discussion of how powerless the student was (since the chief resident had no success), and how vulnerable the student would be if he/she did express concerns. D gave an alternative example of an attending who also did not regularly practice EBM, but was more open to feedback from learners (including students), and requested articles that expressed a different perspective from his own. We concluded that a third goal for the attending (and the system of medical education) was to feel safe teaching using more horizontal power distribution, such that students would be encouraged to share the knowledge they had, and the attending would be more enthusiastic about considering alternatives. There was also some discussion of how comfortable it was to be wrong, or not to know the answers, or ask for help, or admit mistakes. Students claimed they were fairly comfortable with limits of knowledge, but felt the case was different for residents and attendings. E pointed out that students are reluctant to question attendings precisely because they often don't know what the right thing to do might be in any given clinical situation.

C described a situation in surgery where the surgeon seemed to be out of depth in performing an operation. The result was the surgery took much longer than expected, and the surgeon became angry, "blaming everything and everyone but himself." Again, students did not know what to do, and only talked among themselves about what had happened. Patient was then "kept in a coma for 10 days because the staff hated him." We discussed the line where negative feelings cross over into negligence or incompetence. E noted that such behavior is reportable, and B mentioned anonymous reporting. Again, physician arrogance, inability to admit limits, and failure to acknowledge mistakes were implicated. Student vulnerability and limited knowledge were offered as the main reasons why they would not intervene. E raised the question as to what happens to the students' own integrity and moral code when they remain silent in such situations. We also noted when it becomes normative in a system to engage in unprofessional behavior (i.e., the drug-induced coma), widespread support for the action is generated.

The final example came from C, and addressed the issue of residents and staff "making fun of" and "laughing at" patients, either behind their backs or in their presence. Students all could think of examples of this behavior that they had personally witnessed, and most students agreed they had engaged in such behavior themselves. We discussed the importance of group identity, and how patients do not belong to the doctor's group, thus running the risk of being perceived as "the other." Reasons offered for participating in this behavior were 1) catharsis – letting off stream, dealing with difficult emotions such as frustration, dislike, and anger 2) blaming the patient for one's own helplessness or the limitations of the system 3) exhaustion, and a loosening of value-based "screens" or surveillance mechanisms 4) desire to join with and solidify one's relationship to the group. We discussed whether such humor (laughing at rather than with the patient) was dehumanizing to both patient and doctor, and generally agreed that it was. However, F expressed an alternative view that blunt speaking and humor were influenced by cultural and familial norms, and what might be offensive in one context might be acceptable in another. G stated that "poking fun" was "just human nature," and several students agreed. We explored the implications of this statement, and whether it meant that nothing could be done to change what was human nature. F identified a continuum of good-bad behavior, and said that everyone fell somewhere along it. There was some group discussion as to whether "good" people would stay good, and "bad" people would stay bad, regardless of external circumstances. The group agreed that behavior is a result of the interaction of personality (individual goodness/badness) and the values and norms of the society/institution/social system. We decided that the doctoring elective, consisting of course of "good" people, was useful in helping these good people to stay good.

B closed the session with a personal example in which he realized he had discussed a patient anonymously in a social setting for the entertainment value provided. This incident caused him to make a commitment never to discuss his patients again outside of appropriate professional contexts. H questioned whether physicians should be held to a higher standard because of the uniqueness of their profession, as B implied. A reminded students that the purpose of the elective was not to promote special values for physicians, but to help students who wanted to become "better" people, in accordance with the values and ethical standards they had set for themselves, and in the process become "better" doctors as well.

The session ended with mutual good wishes for the holidays.