

Becoming a Doctor -- Critical-Incident Reports from Third-Year Medical Students

"Critical-incident reports" are short narratives of events judged to be particularly meaningful by participants in the events^{1,2,3}. Our medical students wrote such reports at the beginning, in the middle, and in the latter part of their third year, while participating in a required course on the patient-doctor relationship. The students met weekly with faculty members in small groups^{4,5,6}. Assignments for critical-incident reports were open-ended; students were asked to pick an event they felt was important to their learning and to write a short account of it.

An example is this excerpt from a critical-incident report of a third-year medical student who was with a thoracic surgeon examining a patient:

I think we were both surprised by what we saw. Mrs. M was an extremely obese woman who appeared to have spent the last few days sleeping on the street -- she was poorly dressed, extremely malodorous. She greeted us with hostility, telling us how much she hated and distrusted surgeons, that she was merely seeing us out of courtesy to her internist, whom she very much respected.

Dr. R was obviously surprised by her hostility, lacking any patience replied that if she felt this way then there was nothing he could offer. He pointed out that he believed she had an easily resectable tumor, but if it was not treated she might very well die from it. He carefully explained the procedure, its risks, the possible complications. Mrs. M reacted to his bluntness with considerable anger, reiterating her position that she refused an operation. She then got off the exam table and left the room. Dr. R was clearly frustrated by this interaction and reacted with some less than flattering remarks about Mrs. M's personality.

I was also quite upset by this encounter. Here was a woman who had a potentially curable tumor walking away from help. My impression was that she had probably experienced a great deal of pain at the hands of physicians in the past, was not willing to allow them to hurt her again. I felt that Dr. R in letting her leave the room had failed in his job in the most flagrant manner. Had he been more patient, more understanding of her fears, he might have been able at least to win her trust and allow her to

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begin to contemplate the possibility of surgery. I also felt that it was quite clear that Dr. R did not like the patient and he implied that she was the type of person that he did not like on his service.

In this report, a medical student struggles to reconcile his values with becoming a doctor. As demonstrated by critical-incident reports written by students during their third-year clerkships, such struggles are at the heart of the transition from student to doctor. After reading and rereading 100 such reports,⁷ we found that our students' papers focused on a deep-seated conflict -- maintaining empathy for patients while becoming acculturated to medicine -- even though the students rated their clerkships positively overall as educational experiences. More than 95 percent of the incidents described fell into one of four variants of the expression of this conflict.

Expressions of Empathy

Sometimes students strongly identified with their patients. Temporarily trapped in the locked psychiatric ward, a student knocked on the window. A patient stared. The student banged on the window. The attendant stood up slowly, peered at her, recognized her, and let her out. She thought of a patient, Sylvia, who could not get out. More commonly, students acknowledged being restrained by empathy. "Just how do you approach a patient who happens to be your own age, who's just been told he has something growing in his brain?" Or students expressed their feelings as they watched, attempted to alleviate, or sometimes inflicted suffering. While drawing blood for gas measurements from a dying non-English-speaking man, a student communicated with him "through the anguish on my face" so that he would know "that I was suffering along with him."

Difficulty in Acculturating

Some students described their inability to identify with the team of physicians to which they had been assigned. A woman, working with all-male house staff, found them "chiefly oohing and aahing at attractive nurses." She "feigned a wry smile, just to show that I was not a stick-in-the-mud." When a patient agreed to surgery after hearing that "this operation is your only chance," another student concluded that the patient was "browbeaten into agreeing to the operation" by a resident who "used the specter of death almost as a threat."

Clinic staff invested considerable time in convincing a homeless woman to sign in voluntarily for psychiatric treatment.

There was a lot of excitement among the people working with her that maybe it might be possible to have a real therapeutic exchange with her -- maybe she would accept medication. It was at this point that the team found out that the patient's insurance would not cover hospitalization.

She was given \$5 and sent by taxi to a homeless shelter. This student concluded, "The whole incident left me quite confused."

The Struggle between Empathy and Acculturation

In many cases, students recounted their struggles to maintain empathy with patients while assuming the role of doctor. An indigent woman refused to see a medical student in the walk-in clinic. The attending physician explained that it was "a teaching unit" and the patient "had no choice." The patient stormed out. The student wondered "how this patient, who fit the bill for the type of person I had always seen myself helping, actually saw me aligned with Dr. N against her."

Another student described making rounds with a resident:

Dr. X screamed at Mrs. L, "Breathe!" Dr. X slapped her stethoscope on Mrs. L's back, abruptly pushed Mrs. L's shoulder forward. Then Dr. X laughed, embarrassed at her own rudeness. This was a daily ritual. Dr. X made derisive remarks about each patient when we left their room, laughing at her own jokes, patting herself on the back for her wit. The interns laughed nervously. They are team players after all.

This student concluded, "I still like medicine." She had rejected Dr. X's attitude toward patients.

Sometimes students felt betrayed by patients. One "was immensely pleased with myself as I spoke to Mr. Jones," a psychiatric patient. "He frequently began his answers to my questions with 'You see, Rob, what happens now . . .' as if I were a trusted disciple."

Later, Mr. Jones approached.

"Listen, Rob, I can tell you're a man of intelligence. If you could just get back my privileges." Although part of me immediately became aware of his game, the manipulative splitting of the staff that I'd heard of but not yet experienced, I also felt myself being flattered. Perhaps Mr. Jones sensed that I wasn't going to give him what he demanded, but from that point on he opened up less, less. I couldn't help feeling that if I were just a little bit better -- a better doctor, a better conversationalist, more empathic? -- I would be able to break through to him. . . . In a sense, I selfishly used Mr. Jones much as he had used me. I consistently looked to him to bolster my fragile confidence in my abilities as a physician and empathic listener.

Students were sometimes aware of withdrawing from intimacy with incontinent or grotesque patients at the moment when these patients needed understanding. A young man who had undergone radical neck dissection

would look at me with appreciation, his eyes would say "I'm okay," but a couple of days later he was coughing terribly and trying to push phlegm out through his tracheostomy by producing a huge breath and a cough. He dripped phlegm on my jacket and my hands as I tried to assist him. I didn't

make a big deal out of it and just wiped it off. About four days later I came down with a horrible flu. Later, when the patient deteriorated, he seemed barely human. Could he see the horror in my eyes?

Another student "wandered around looking for someone to explain" after witnessing a failed attempt at cardiopulmonary resuscitation.

I was really not sure what I wanted to ask anyway -- not about the medical reasons for what was done. What I wanted to know was how it felt to be invading someone's body when there was so little chance of it being any use., how to switch quickly from being intensely involved in something so personal as death, to acting business-as-usual.

Blending Empathy with Acculturation

Students maintained, and even used, empathy in vexing situations. One student saw the viewpoint of a patient "who was cold toward me no matter how much warmth I extended." The student said, "I am sure that I will not like every patient. Just because a doctor dislikes a patient does not mean that the patient should receive less." Another student compared communicating with the wife of a patient who had had a devastating stroke with her own experiences when her uncle suffered a fatal stroke. She did for the patient's wife what she wished her uncle's doctors had done for her: she provided support.

A student took a personal interest in T.C., a 39-year-old man with AIDS, whom everyone avoided on rounds. The student became the liaison between the patient and his doctors. He successfully advocated giving T.C. more control over his medications. When T.C.'s cryptococcal meningitis worsened, the student took part in telling him. This student concluded, "I think I had an impact on T.C.'s life; he certainly impacted on mine. If I witness his death, I will add one more image to the many already engraved in my mind. What he taught me will always be with me."

Another student inflicted considerable pain while doing a pelvic examination. She concluded that she did not want to stop feeling remorse, which ensured that she would not lose sensitivity. The same student encountered a comatose young victim of a bicycling accident surrounded by his family. She maintained her distance, but felt sad. She reflected that her own brother, who was 20 years old, could have been involved in a similar accident. She wondered if doctors are like voyeurs, but she concluded that she herself felt genuine grief over the death of the patient and "over my inability to reach out and console his family."

Another student felt that the care of his patient consisted of a lot of tests that failed to relieve suffering. On reflection, he concluded that his anger at his team "for not caring more" reflected his search for a convenient target for his own frustration. He wished he had acknowledged his patient's suffering.

Role models were often helpful. A student's pregnant patient had premature rupture of the membranes. The resident assigned to the case hastily and perhaps arbitrarily declared the discharge "purulent" and initiated labor. "With each contraction, the patient's grief seemed to wrack her body, and with the delivery of her tiny infant, still moving in its sac, her sobbing seemed to come from deep inside." This student found solace after talking with a nurse, who herself had delivered a stillborn child. She wrote that she had learned from the compassion and resilience of the nurse, sufficiently so that she could continue to become a doctor.

Students read their critical-incident papers aloud in the groups. As faculty members, we at times responded by sharing our own descriptions of critical incidents. We discussed questions such as what happened, why, and what alternatives or solutions existed. Above all, we listened closely, attempting not to push students to reveal more than they wished, and we tried to help them to clarify their feelings while seeking to gain perspective on the events themselves. Sometimes we were available after class to talk with them. Our students' papers helped us to understand the importance to them of reconciling empathy with patient care, and we hope this understanding enabled us to become better teachers.

Efforts like these to help students keep alive their best instincts and values -- efforts we share with teachers at medical schools across the country -- deserve to be at the heart of medical education.

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