

The Case of the Backroom Blunder

Case Written by Heather Murray

Case

Dr. Heather Murray

Objectives:

Dr. Teresa Chan

Expert Responses

Dr. Brian Goldman

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Curated Community

Commentary

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Trevor, the 3rd year medical student rotating in the Emergency Department, sat down in the staff changing room to gather his thoughts. He had never seen a cardiac arrest before, and this one had been a doozy. An elderly, obese man had come in by EMS after suffering cardiac arrest from a huge lower GI bleed. The ED team had run the arrest for a really long time, transfusing blood, IV fluids and tons of drugs, intubating, bedside ultrasound, everything. The room had been a mess when they finally called it. Trevor had gone with Dr. Elliott, the attending, to break the news to the family. He had been impressed with her gentle compassion as she talked with them.

Trevor was thinking about the code. He was pretty pleased with his CPR - he'd practiced in the sim lab to get the timing and compression depth just right. Dr. Elliott had even complimented him on it. He thought about the smell - melena, rectal bleeding, vomit... it had been really awful. He hoped they could make the room smell better before the family came in. They had been so upset. He thought about the rest of the code. It seemed like Jeff, the senior resident, had struggled with the intubation. There had been quite a scene at the head of the bed. Jeff had needed 3 extra suction catheters to deal with all the airway vomit. Dr. Elliott had even asked if Jeff wanted her to take over. Trevor thought that it should have been a bit smoother.

He got up and left the change room. As he was about to come around the corner, he overheard Dr. Elliott and Jeff talking. He stopped, not wanting to interrupt, but as he listened he realized they were laughing together about the code! He heard them making jokes about the smell and the rectal bleeding, calling the patient a "frequent flyer" and talking about his "red underpants." They didn't seem to care at all that he had died, or about how awful it had been. And Jeff had screwed up the airway, Trevor was sure of it. Shouldn't he be apologizing to Dr. Elliott instead of laughing? Dr. Elliott had seemed so nice and sympathetic to the family... was that all pretend? A fake show of sympathy?! Now Trevor was angry.

After Dr. Elliott and Jeff went back into the ED, Trevor stayed in the back hall, fuming. Sonia, another 3rd year student, arrived for her shift. When Trevor told her about Dr. Elliott and Jeff's conversation, she pursed her lips and thought for a minute.

"Weird. Dr. Elliott always seems like she cares about people to me. Maybe it upset them, too? Maybe they're just blowing off steam?"

"No way. A caring doctor would never talk like that. And the slang? That's just awful. That man was somebody's dad, and grandpa. I'm thinking of writing a complaint."

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Questions for Discussion

1. Medicine has a lot of slang - words that are specific to our particular culture, and sometimes derogatory. Is there a role for this language? Should medical educators be held to a higher standard?
2. Black humour has been used as a coping strategy for stressful or traumatic events. Is this appropriate in a patient-centered care world?
3. How should physicians cope with stressful or horrifying situations? How can we "blow off steam" effectively, and how can we support our learners?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Patient Centered Communication (ICS1) Accountability (PROF2)	Professional Communicator

Intended Objectives of Case

1. Describe the relationship between stress and humour.
2. Describe the differences between slang and workplace-based lingo.
3. List various slang terms used at your institution. Outline possible misinterpretations (i.e. how patients or other non-healthcare practitioners might view these terms).
4. Discuss the ramifications of using humour and slang in the workplace,
5. Draw linkages between the following topics: humour, coping, resilience, compassion fatigue and burnout.

Slang and Medical Culture

by Brian Goldman MD, FACEP, MCFFP(EM), FCFP

If Sticks and Stones could Break your bones...

The terms 'red underpants' and 'frequent flyer' are examples of slang – referred more formally by linguists as argot, which is defined by the Merriam-Webster Dictionary as “an often more or less secret vocabulary and idiom peculiar to a particular group.” The purpose of argot is to prevent eavesdropping outsiders from understanding what you’re talking about and to create a bond among colleagues, teammates or friends. Medical argot is simply English augmented with code words that are incomprehensible to all but those in the know.

In general, argot or slang may be used to describe undesirable or frustrating patients. An example used commonly is “frequent flyer,” which refers to patients who return again and again. Some use the term because they believe the repeat patient is gaming the system for benefits such as food, bandages and taxi chits.

There is little published evidence of medical argot. A 1993 survey of American physicians found that slang is learned in the clinical setting and therefore uncommon until the third or fourth year of medical school. That survey found that the use of slang peaks during the first post-graduate year, and begins to decline throughout the residency years, and by 20 years of practice, admitted self-knowledge of slang terms being only marginally higher than that of the preclinical medical student[1].

In researching my book *The Secret Language of Doctors*, I found a number of anecdotal collections of argot. While I agree that residents are more likely to use argot, there is evidence that slang is also used by some attending physicians[2]. A 2012 study by Reddy and colleagues at the University of Chicago found that 40.3% of hospitalists surveyed admitted to making fun of other physicians, 35.1% made fun of other attendings to colleagues, and 29.8% admitted to making disparaging comments about a patient on rounds[2].

Is there a role for this language?

If slang words are used, then, their use is proof that the language serves a purpose.

Coombs and colleagues wrote that slang helps young doctors overcome anxieties encountered during medical training and practice – those anxieties arising from clinical

and diagnostic uncertainty, the difficulty treating fellow human beings, and an attempt to distance oneself from disease and death[1].

The anxiety associated with diagnostic and clinical uncertainty doesn’t get its due in common medical discourse. In her brilliant book *Experiment Perilous*, Dr. Renee Fox, one of America’s preeminent sociologists, wrote at length about the challenge of dealing with therapeutic uncertainty faced by physicians working in the 1950s at the Medical Research Group in Boston.

“What the physician can do to help a patient, then, is often limited. What he ought to do is frequently not clear. And the consequences of his clinical actions cannot always be accurately predicted. Yet, in the face of these uncertainties and limitations, the physician is expected to institute measures which will facilitate the diagnosis and treatment of the problems the patient presents.”[3] Looking past the use of gender-exclusive pronouns, Fox identified a core anxiety that is as pervasive today as it was back then.

Terms like ‘social admission’ or ‘dyscopia’ (i.e. ‘failure to cope’) symbolize the helplessness perceived by residents and attending physicians that a good deal of medical care delivered these days is medically futile. Futility is as often discussed in hospital corridors as it is misunderstood by health professionals[4]. In the same vein, the slang term frequent flyer calls attention to the growing problem of readmissions and repeat visitors to the ED. In my opinion, it is better to acknowledge evident problems in health care than ignore them. The problem with the label frequent flyer is that the term blames the patient, when there’s a growing evidence that repeat visitors are system failures that can be addressed[5].

Although argot may be useful to reduce physician and trainee anxiety, there is no question that slang or argot is often unprofessional[6]. The real issue is what to do when one hears it. Acolytes of medical professionalism might argue that slang should be called out and (if possible) stamped out of hospital discourse. The problem with that strategy is that it drives the use of slang underground.

Just because physicians no longer write odious terms such as FLK (funny looking kid) in medical charts does not prove that the term is no longer spoken.

Expert Response

A better approach for medical educators is to notice the slang and – when heard – to ask questions about the frustrations that contribute to its use. Medical educators have a higher obligation to model behavior that is respectful to patients, colleagues and allied health professionals. Pejorative slang tends to be learned avidly by residents and students when the teacher is an attending physician.

Black Humour

Physicians have long used black humour to help cope with anxiety-provoking situations as well as frustration at not being able to cure or even help every patient. Experiment Perilous is replete with examples of what Fox refers to as gallows humour.

There are many suggested purposes to gallows humour. Unlike normal discourse – with its many qualifiers and modifiers that tend to soften the rhetorical blow – gallows humour to the truth in a hurry. Gallows humour often mirrors power relationships. In medicine, it's considered acceptable for residents to joke about attendings but not the other way around. In that context, gallows humour regarding patients may reflect the powerlessness that physicians feel about treating patients who cannot be helped by modern medicine.

In the past, gallows humour was regarded as therapeutic to health professionals and even necessary to their wellbeing. However, the rise of medical professionalism, has led to re-evaluation and even condemnation of its use. As Katie Watson wrote recently: "Critics of backstage gallows humour who are admirably concerned with empathy for patients sometimes seem curiously devoid of empathy for physicians. Medicine is an odd profession, in which we ask ordinary people to act as if feces and vomit do not smell, unusual bodies are not all that remarkable, and death is not frightening." [7]

To draw the line between appropriate gallows humor and conduct unbecoming a physician, Watson suggest we think about who is harmed by the joking. Jokes about defenseless patients are off limits; jokes about doctors who are defenseless or ineffective against death, decay and chronic illness are not. If the joke harms the patient's access to decent care, that's verboten; so, too, is humor that diverts attention from structural problems in the system by personifying them.

Humour that helps those on the front lines cope with oppressive situations is okay, while humour that mirrors the relationship between bully and victim is not.

How should this case be handled?

Slang and joking that enables physicians to open up about difficult experiences can be therapeutic, while language that cuts them off from their colleagues and themselves does not serve the same purpose. I side with those who believe slang and gallows humour – constructed along the lines just mentioned – serve a therapeutic purpose without harming patients. Used to cope with extraordinary situations such as the one witnessed by Trevor, gallows humour may be in – in the words of Watson – a "psychic survival instinct." Such displays of humour should take place far away from patients and families.

Trevor's point of view is extremely valid. Were he to complain to his supervisor or program director about the conversation he overheard between the attending and the resident, there's a good chance the participants in that conversation would be admonished for modelling unhelpful behaviour. Far better if the next time, Trevor is included in the circle, where he can raise his legitimate concerns, where his higher-ups could defend their responses to the failed resuscitation, and where all three of them could reflect upon what happened and how that affected them.

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About the Expert

Dr. Brian Goldman (@NightShiftMD) is an attending ED physician at Mount Sinai Hospital in Toronto and an Assistant Professor at the University of Toronto. Since 2007, he has hosted *White Coat, Black Art*, the award-winning show on CBC Radio One about modern medical culture. His TED talk 'Doctors Make Mistakes, Can We Talk About That?' has been seen more than 1 million times. He is the author of *The Secret Language of Doctors*, a bestselling book about hospital slang and modern medical culture.

Expert Response

We don't cry in critical care, we tend to laugh and joke and be sarcastic...Why?

by Liz Crowe BSW, PhD(c)

The use of humour, swearing and occupation specific language/jargon to cope with dangerous, emotional and traumatic settings is well documented amongst critical care workers [1]. Black or gallows humour was first identified as a phenomenon in the World Wars [2] and is intellectualized as a type of humour that arises in precarious, dangerous or confronting situations as a means to manage negative emotions and consequences to mental health and reduce stress [3]. According to various studies [1,3-7], humour in the critical care context has been identified as a useful tool to:

- Reduce tension, stress and anxiety
- Vent emotions
- Distance oneself from the intense emotions and the confronting nature of the situation
- Re-interpret events and re-frame personal distress
- Distract from the horror and distress
- Ensure individuals continue to perform in the job
- Regroup personal resources
- Create a 'psychological reset' to ground people out of their high adrenalin state.
- Build bravado and strength amongst the team in times of crisis.
- Develop group cohesion
- Allow a sense of playfulness amongst the team
- Elicit social support
- Humour, swearing and crassness in critical care bonds teams together forming a psychological defence system against the work.
- May provide a sense of group membership and identity that is quite separate from the individuals' behaviour in their personal lives.

In this case, ensuring that Trevor understands the role that humour may play in various environments may be of value. An awareness of the use of humour in the critical care context would allow individuals to view Dr. Elliott and Jeff's behaviour with a compassionate and understanding framework.

Norms & Explanations

Community expectations of the range of skills that critical professionals will possess are growing. We are all meant to be skilled and clever clinicians who can make death an 'option'; wonderful educators, counsellors and communicators and be able to absorb any situation and mind our own self-care all on top of our long and often exhausting work schedules. These expectations are unfair and unrealistic. Each one of these traits is a skill that needs to be developed, nurtured and mentored over time. When we have students of any occupation in our care it is

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wise to speak with them early about the many strategies that people will use to distance themselves and survive the often confronting, perverse and tragic environment of critical care. Humour, swearing and crass jargon are part of our 'armour' in surviving this work. Providing orientation early for new staff and students can prevent these folks from becoming disillusioned and feeling isolated. For Trevor, this may have been particularly useful, since it may prevent him from feeling isolated from his peers and mentors.

Humour can be an adaptation to stressors or social phenomenon for members of the emergency services, but has also been used by those who work in defence forces, funeral homes and even the sex industry. Humour is often used to incorporate new members to the team. Jokes and stories may be used to educate and orientate new members in a way that is jovial though builds realistic expectations and warns of the work and chaos that will ensue [7].

Humour as an Adaptive Strategy

The nature and culture of the critical care environment means clinicians will often find themselves unable to situate themselves easily on the continuum between empathy and detachment[8]. Context specific variables (mood, previous experiences, personal attachments) will force clinicians to change their location within this spectrum. They will slide up and down this empathy-detachment continuum. At times they will be deeply empathic and connected to patients, families and situations, and then at other times they might detach and distance themselves from the event by using humour and crass language to protect themselves from emotions. At times, this detachment will be adaptive, in that it may allow the provider to move quickly onto the next patient and situation as is the requirement of our work. This is a skill that Dr Elliott has clearly mastered; He is an empathetic and connected attending with his patients; but then adaptively laughs and reframes the situation with colleagues in the backroom.

Similar to our medical student Trevor, people new or external to the critical care context may be easily offended and shocked by the humour used amongst workers with little understanding as to the pressures and tragedy of the job. However, it appears that those who want to emotionally survive the critical care environment will need to share a sense of the absurd and enjoy humour as part of the job in the way that Dr Elliott and Jeff are doing after what was obviously a gruesome and confronting event[9].

Expert Response

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About the Expert

Liz Crowe is an Advanced Clinician Paediatric Social Worker who has worked extensively with children and families impacted by grief, loss, trauma, crisis and bereavement since 1995. She currently works as an Advanced Clinician Social Worker at the Brisbane Mater Children's Paediatric Intensive Care Unit and as a Program Facilitator at Griffith University researching the use of Advance Care Planning. She is currently doing a doctorate exploring Staff Wellbeing in the Paediatric Intensive Care Unit with an aim to developing formalized interventions and education programs for critical care health professionals, including communication skills for health professionals and teams to ensure optimal outcomes for staff and families. She is the successful author of 'The Little Book of Loss and Grief You Can Read While You Cry'. Liz is a passionate and humorous educator who can captivate audiences on a range of subjects.

Curated Community Commentary

By Heather Murray MD, MS, FRCPC and Teresa Chan MD, FRCPC, MHPE(c)

A qualitative methodology was used to curate the community discussion. Tweets and blog comments were analyzed, and four overarching themes were extracted from the online discussions.

There was a huge online response to this case, and a rich and nuanced discussion occurred, both in the comments section and on Twitter. A number of themes emerged, which are summarized below. In this summary we aimed to highlight issues that are particularly important for practitioners in the emergency department (ED), but the blog comments host a wide breadth of information that is applicable to nearly all healthcare professionals.

The Use of Slang

Medical slang use was discussed extensively and a few differing perspectives emerged. There seemed to be general agreement that slang that is explicitly derogatory towards patients is inappropriate. However, there were differing perspectives about exactly which terms are “inappropriate.”

Some commenters felt that any slang language in health care is derogatory and as Michelle Gibson stated: “reveals how people really feel about patients.” Others emphasized how language can perpetuate stereotypes or misconceptions, implicitly endorsing certain elements of the healthcare culture.

Jon Bennetson stated that he was appalled by the use of medical slang:

“What’s shocking to me is that this kind of patient-denigrating language is seen as so professionally acceptable by doctors that it routinely appears in their publications and medical magazines and no doctors complain about this language.” Specifically he referred to general practice trade journals that use medical slang in their publications.

Others felt that it is not the terms themselves but the intent and tone used that determines the attitude of the physician or care provider. Carolyn Thomas admitted that she has experienced depersonalization as a patient in the hospital setting. However, the slang in the case did not bother her but instead she found the laughter of the caregivers offensive: “High hilarity over a patient’s rectal bleeding ... should be as chilling an observation to health care providers as it feels to me.”

Slang terms, however, can be used to convey messages between providers. As Teresa Chan noted, medical slang

may parcel information for efficient communication. Loice Swisher agreed:

“Knowing a person is a ‘frequent flyer’ tells me that I likely have information available from prior visits as to what has been tried, tested and offered. It may give me a clue that being the 6th doctor to see a patient with unexplained abdominal pain that I might not be able to provide an answer and that I need to help the patient get on a new path out of the ED revolving door. It could mean that there are underlying social or financial issues that might have some assistance available.... That doesn’t mean I think less of the patient as a person.”

One of the other hazards of using such terms is that it can affect your decision making. Anand Swaminathan cautioned that the term “frequent flyer” may lead to premature closure and compromise diagnostic reasoning. Similarly, some debated the use of the term ‘acopia’ or ‘failure to cope’, highlighting that this can similarly lead to premature closure around a patient’s particular scenario, as has been suggested in previously in the literature (1).

Black humour:

A coping mechanism for stress and trauma

Most commenters agreed that both slang and black humour are methods of creating emotional ‘distance’ from difficult scenarios, which necessarily depersonalize the patient. Participants were split about the merit of this particular coping technique.

Many of the emergency physician commenters pointed out that in the rapid paced ED, the ability to emotionally switch from one patient to another is a survival skill.

As Anne Marie Cunningham stated: “...the strongest theme emerging from the discussion is that black humour/derogatory language is not a sign of not caring, but a sign that doctors are under pressure. Can they be given time and space for better ways of coping? That seems to be the challenge.”

Kate Bowles shared her experience as a patient:

“From my experience and discussion with other patients, we also hide the humour a bit around staff. There’s a kind of illness professionalism in patients too, weirdly. There isn’t an answer to this; I’m just suggesting that maybe there’s some black humour being used to cope on both

Curated Community Commentary (continued)

Meanwhile, Jon Mendel wrote that he believed power dynamics within a relationship determines the 'acceptability' of the use of black humour or slang (i.e. black humour may be fine for patients to use, but not for their doctors).

Table 1 discusses a selection of the pros / cons of medical practitioners using Black Humour as a coping strategy.

NB: For more on Gallows humor, this article by Elizabeth Sullivan in the [Psychologist magazine](#) was a suggested reference.

Learners & Black Humour

This case also highlighted the importance of incorporating learners into the discussions around black humor.

Loice Swisher suggested that perhaps what Trevor witnessed was a very unique EM skill set that he was not accustomed to seeing: Emotional Shapeshifting. As Liz Crowe observed, immediate compartmentalization of emotions may be a necessary strategy required of a busy

emergency physician so that they can stay sharp, complete their shift and take care of the many other ED patients requiring assistance. Loice states: "We are trained to rapidly change for one situation to another while making every attempt to have our demeanor match the need. When one observes this shifting to find where the other person is, well, it can be confusing and seem deceiving."

In the following quote, Stella Yiu eloquently described the insidious nature of how teachers might not be fully self-aware of our practices in this regard, and how this might affect our teaching around such cases: "It might be such a gradual process and not so explicit to ourselves ... that we never see it as such and therefore do not explain it to our learners. We have all thought about patients and cases long after the shift has ended when the full impact of 'who' they are hit us - and the learners clearly do not see this (or do not have this explained to them later)."

One medical student (Eve Purdy) stated: "it is desperately uncomfortable when you see superiors making light of a situation that has really shook you. It slams any door shut to debriefing." Her sentiments are echoed by those previously reported in the literature (2). Medical students have been shown in previous studies to be a very

Table 1 The pros / cons of medical practitioners using Black Humour as a coping strategy.

Pro	Con
<p>Anand Swaminathan: "Black humor is important in all fields of medicine and particularly in EM. We see the worst that society has to offer on a regular basis. We see terrible things happen to good (and bad) people every day. I think depersonalization is critical for us to keep our sanity."</p> <p>Stella Yiu: "We gradually built our armour of coping/defense mechanisms for our hectic daily work. I would even go further and suggest that sometimes when the situations are dire, we 'need' to depersonalize so we can focus on tasks and decision-making objectively rather than being swept up in emotions. I think that mechanism of separating illness from the person works well (for say, a pediatric code, a disaster etc.) that we started using it for other patients as well."</p> <p>Liz Crowe: "Cruel and inappropriate humour may not always be immature coping mechanisms. However they are often only first line of defence - coping mechanisms that allow individuals to continue with several hours of difficult and busy shifts that lay ahead. However, for many they will then need to unpack their emotions, review their intentions and work through their emotions and experience of the event. We are all really different."</p>	<p>Jordan Grumet: "Ultimately, I found that gallows humor and slang were immature coping mechanisms, Becoming cruel and callous would neither shield me from the pain or save me from my own failings...We currently face a most difficult period in medicine. Burn out is at an all time high, and physician suicide is the topic gracing the pages of our most prominent periodicals. Our coping mechanisms are not working. We must stop making our patients the butt of our grisly humor."</p> <p>Carolyn Thomas: "Some may blow this (laughter) off as merely stress-releasing, as if it were somehow effective, instead of what it actually is: a symptom of depersonalization that is ultimately the slippery slope to career burnout."</p> <p>Amy Price: "Dark humor does not help long-term and it short circuits ways of coping and re-framing and real support through the dark times when we give our all and the effort is death or destruction."</p> <p>John Cosgrove: "...many are themselves uncomfortable with hearing black humour and associated derogatory language and believe it to be immature and indicative of lack of caring."</p>

Curated Community Commentary (continued)

idealistic bunch that desire to be humanistic physicians, able to maintain empathy, ethics and honesty (3), and encounters such as this one may lead to dramatic changes in their perception.

Many participants thoughtfully articulated the treacherous slippery slope that black humour can open up, especially when learners are involved. One brave resident (Sarah Lockett-Gatopoulos) even noted that as she has journeyed up the ranks in medical education she finds herself using terms that she might have found alarming as a medical student. This maps with findings from the nursing literature

Indeed, medical educators and clinical teachers alike need to be cognizant of the impact on their development. Role modeling may be the most potent of teaching strategies, especially in the workplace. (4) As Jonathon Tomlinson highlighted:

"Behaviour is contagious...the importance of role modeling is probably beyond dispute. We learn ways of coping from our peers, gallows humour is one of several ways we cope, but it is a problem if it is the predominant or only way of coping because it is very unlikely to be suitable or sufficient for all the members of a team."

Participants all seemed to concur that the hidden curriculum may manifest in these scenarios, and if not properly addressed (or debriefed) may lead to changes in learner behaviour. (5,6)

A Call To Action: **Finding alternative strategies for fostering resilience**

Specifically, studies have shown that emergency medicine trainees are frontline worker that may be particularly susceptible to the stresses of providing clinical care (7).

Time available for debriefing in the ED was explicitly identified as a challenge. Bearing this in mind, participants did make numerous suggestions for how we might better foster resilience in healthcare providers. This is a particular salient issue since there are increasingly high profile instances of PTSD, compassion fatigue leading to burn out and suicide in our healthcare colleagues.

Discussion participants agreed that there is very little formal and informal training in debriefing critical events. Loice Swisher linked an paper which showed that 88% of Peds EM fellows have no debriefing training, despite the majority (90%) wanting to access it (8). Amy Price and Liz Crowe both advocate for more in depth training at all levels in grief management and resilience. Jonathon Tomlinson, like other writers before(9-10), suggested there might also be further opportunities for training in professionalism education:

"Instead of telling doctors and students how they (should) behave we should advocate for humane working conditions and make time for all healthcare professionals to discuss their work through peer supervision, (like the Schwartz rounds other have mentioned) and in ways that give a wider range of opportunities to cope."

Jonathon Tomlinson points out some studies which support alternate methods for professionalism education including Launer's narrative-based supervision (11) and Greenhalgh's educating for complexity (12). He also highlighted the University of Westminster's Compassion and Resilience in the NHS series (13).

Meanwhile, there may be also a role for expanding the training to include the practice of empathy in the clinical setting (14), since previous studies have shown that clinical exposure alone is not sufficient (15).

All these issues must be kept in mind as we go forward in designing curriculae for our learners. Of note, the origins of cynicism and emotional distance may begin as early as the first clinical exposure for some (i.e. usually third year of medical school) (16).

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Curated Community Commentary (continued)

Resources suggested during this discussion

1. EMCases Episode 49, [Effective Patient Communication, Patient Centered Care & Satisfaction](#).
2. Maben, J., Latter, S., & Clark, J. M. (2007). [The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study](#). *Nursing Inquiry*, 14(2), 99-113.
3. [Attitudes and Habits of Highly Humanistic Physicians](#)
4. Launer J. [Conversations inviting change](#).
5. [Schwartz Centre Rounds](#)
6. Webster F, Rice K, Dainty KN, Zwarenstein M, Durant S, Kuper A. [Failure to Cope: The Hidden Curriculum of Emergency Department Wait Times and the Implications for Clinical Training](#). *Academic Medicine*. Online first September 30, 2014. doi: 10.1097/ACM.0000000000000499

Videos:

1. Dekker S. Just Culture. <http://www.youtube.com/watch?v=t81sDiYjKUK&feature=youtu.be>
2. Maben J. Care, Compassion and ideals: Nurses' experience of nursing. <http://www.youtube.com/watch?v=0zR7gJo5fak&feature=youtu.be>
3. University of Westminster's Compassion and Resilience in the NHS series. <http://www.westminster.ac.uk/resilience/news/compassion-and-resilience-in-the-nhs-lecture-series>

Resources that were authored by participants in this discussion:

Anne Marie Cunningham
[Social Media, Black Humour, and Professionals](#)

Jonathon Tomlinson
[Do Doctors need to be Kind?](#)
[Doctors and Empathy](#)

Stella Yiu
[Loss of Innocence](#)

About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

Did you use this MEdIC resource?

We would love to hear how you did. Please email MEdIC@aliem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

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[Swearing your way out a crisis](#) (by Chris Nickson; the podcast on the page is by Liz)

Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

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