

The Case of the Not So Humorous Humerus

Case Written by Dr. Amy Walsh; Edited by Dr. Teresa Chan

Case

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Objectives:

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Expert Responses

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Curated Community Commentary

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“Hey, do you have time to hear about one? I think we can get her out of here pretty quick,” said Sean, a third year residents. “She seems kind of dramatic. She was trying to get up from her chair last night, her legs got tangled and she fell. She’s complaining of severe arm pain and says that she hasn’t been able to use it since the fall. I think it’s just a deep bruise, but I can’t get a very good exam because she screams every time I touch her arm, so I guess I’ll get some x-rays. Oh, and she has lupus, no other health problems.”

You walk into the room to staff the patient. Mrs. Johnson is obviously uncomfortable, but you understand Sean’s perception that she was dramatic. Armed with the x-ray, you have the benefit of information that your resident did not. Her years of chronic steroids had led to a proximal humerus fracture after relatively mild trauma. You finish up your history and exam, and inform Mrs. Johnson of the plan. “So, we’ll give the Orthopedic surgeon a call. They’ll come see you, and you might need a surgery – but at the very least you might need adjustments to make sure you’re safe at home using your walker. Can I get you some medicine for pain?” you say, as you are leaving the room after staffing the patient.

“Yes, please. Thank you so much for listening to me. I think Dr. Peters thought I was faking. It seemed like he was almost laughing at me when he was in here. He kept asking me what I was crying about, and trying to get me to get up and try walking. I wouldn’t come here unless I was really in pain, so that made me pretty upset.” Mrs. Johnson said.

“Oh? I’m so sorry to hear that. We’ll make sure everyone takes excellent care of you from here on out, and I’ll discuss this with Dr. Peters.”

You step out of the patient’s room and see Sean putting in orders on another patient. This seems to be a good time to have this discussion with him.

Questions for Discussion

1. How do you address the patient’s concerns with Sean?
2. What do you expect of Sean to make it right with the patient?
3. How do you work through the encounter to make it a learning experience for him, and to help him identify the behaviors that were offensive to the patient?
4. How much do you delve into the resident’s personal issues that may be leading to compassion fatigue?

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Competencies

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

Intended Objectives of Case

1. Describe appropriate strategies for debriefing difficult situations in the clinical setting.
2. Describe appropriate approaches for addressing patient concerns.
3. List potential causes of unprofessionalism in the workplace.

Compassion Fatigue & Feedback

by Felix Ankel MD

This case is common and offers the learner a teachable moment in communication and situational awareness and the teacher an opportunity to hone the skills of feedback, cadence, and maintenance of boundaries.

Jack Ende's 1983 JAMA article "Feedback in Clinical Medical Education" remains a classic and offers eight goals of effective clinical feedback.(1) He suggests that feedback should:

1. Be undertaken with the teacher and trainees working as allies with common goals
2. Be well-timed and expected
3. Be based on first-hand data
4. Be in small quantities and limited to behaviors that can be remediated
5. Be in descriptive non-evaluative language
6. Deal with specifics, not generalities
7. Offer subjective data labeled as such
8. Deal with decisions and actions, rather than intentions or interpretations

Communication with the resident in this case may be influenced by the opening and cadence of the feedback. Consider opening with a soft invitation for feedback. E.g. "Can I give you some feedback based on the information I received from Mrs. Johnson". If an agreement to discuss Mrs. Johnson has been reached, I suggest limiting the feedback to the facts of the case and ask for Dr. Peter's reflection. Based on the reflection, the attending may see the depth of Dr. Peter's insight and adjust the cadence of subsequent feedback.

If Dr. Peters shows deep insight, I suggest the attending coach the resident on the anatomy of a patient apology and have a further discussion after the shift. This would be a better time to discuss compassion fatigue and situational awareness. Depending on the circumstance, a more in depth discussion could open the door to further discussion on depression, substance abuse, and personal relational challenges. If Dr. Peters shows limited insight, the attending should set guidelines for expected behaviors with clear consequences and discuss his

concerns with the program director if continued communication issues occur.

Some programs are attempting a residency culture shift towards compassion through design thinking.(2) Some have incorporated Schwartz Center rounds (3,4), an interdisciplinary forum where attendees discuss psychosocial and emotional aspects of patient care.(5) Others have partnered with the Institute of Patient and Family Centered Care(6), which offers resources and patient advisors to programs wishing to embark on a patient centered journey. Ultimately the combination of a residency culture focused on compassion with consistent 1:1 individual resident feedback will lead to residents with superior patient communication skills

References

1. Ende J. Feedback in clinical medical education. JAMA 1983 250:777-781
2. http://en.wikipedia.org/wiki/Design_thinking
3. Lown B, Manning MA. The Schwartz Center Rounds: Evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. Academic Medicine 2010 85:1073-1080
4. Schwartz Center Rounds. The Schwartz Center. Retrieved on March 17, 2014 at <http://bit.ly/MZBeNG>
5. Ankel, F. Royal College Program Director Podcast. International Conference on Residency Education. Retrieved on March 17, 2014 at <http://icre2011.files.wordpress.com/2011/03/pd-podcast-ankel.mp3>
6. Institute for Patient and Family Centered Care. Retrieved on March 17, 2014 at <http://www.ipfcc.org>



About the Expert

Felix Ankel, MD, vice president and executive director of health professional education, HealthPartners Institute for Education and Research. Felix is a former emergency medicine residency director and current Accreditation Council for Graduate Medical Education (ACGME) designated institutional official for Regions Hospital in Saint Paul, MN. He is an associate professor and assistant dean at the University of Minnesota and serves on the board of directors for the Council of Emergency Medicine Residency Directors. In 2012, Felix received a Parker J. Palmer Courage to Teach Award winner, given by the ACGME. His interests include competency-based medical education, and disruptive educational techniques. Annually, HealthPartners Institute trains more than 470 residents and 2,000 clinical students. The Institute also provides state-of-the-art simulation training and maintains online medical learning resources for the

Seven Tips for Improving the Patient Experience

by Anne Smith MBChB, FCEM(SA), Mmed

The discussion points in this case hinge around three main topics:

Patient expectations:

Patient expectations vary with age, gender, cultural background and previous medical history. Some expect or associate physical touch with a more 'caring' doctor, while others would prefer not to be touched unless being examined. Some prefer a more conversational style of consultation while others would engage more with a more formal, fact based type of consultation.

One of the skills we must learn as EM clinicians is how to quickly make our patients feel comfortable and trusting of our clinical skill and decisions. We don't have the luxury of time to build long term relationships - we are expected to delve into peoples' most intimate secrets after only a few minutes! We work in clinical areas that are often busy, noisy, filled with distractions and not very private. Our attitudes and personal communication skills go a long way towards putting our patients at ease.

Our patients have right not only to excellent medical care and appropriate diagnoses, but also to a pleasant human experience while in our care.

Doctors attitudes:

Sometimes it is hard to explain why we feel the way we do towards our patients. We need to be aware of how our own prejudices and personal issues may affect our consultation and decision making skills. If we are tired, hungry or had a previous negative experience with a particular type of patient, this may adversely affect their attitude towards them.

Compassion fatigue may result from external factors (long working hours or heavy on call duties) and internal factors (personal mental health issues or physical illness). It is our responsibility as educators and mentors to watch for evidence of compassion fatigue in those working with us and to address problems before patients suffer.

Cognitive errors:

We all make cognitive errors during consultation, particularly when we lapse into intuitive thinking rather than deliberative thinking. These errors may get worse in busy units, or with physical stressors like lack of sleep.

One example of a cognitive error in this case is anchoring, or anchor bias: Sean may have decided early on this consultation that she didn't have a fracture and that the x-ray would be done simply to appease the patient. He may have neglected looking for other potential complications that a fracture could cause as he had already decided this was a 'deep bruise'.

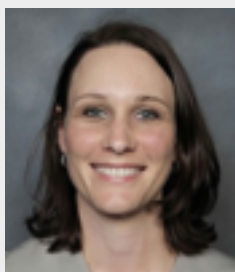
In summary:

You can try some of the following to improve your patient experience:

- 1) Introduce yourself and your role in the ED: It sounds simple, but it is easily forgotten.
- 2) Ensure that the patient is comfortable before you start your consultation and try maintain their dignity and privacy as much as possible,
- 3) Listen to the patient and let them tell the story in their own words. This can be frustrating, but interrupting and asking closed-ended questions may cause us to miss critical information.
- 4) Practice self-reflection: During and after the consultation, ask yourself how you think it is going/went and what the patient is experiencing. Note any irritation or distraction in yourself and try to pinpoint why you are feeling that way and how it is affecting your patient contact. Physical stressors like hunger and tiredness, as well as psychological stressors like a full waiting room may impact your bedside manner.
- 5) Practice with simulation: This case could easily be practiced in a role-play or simulation scenario.
- 6) Beware of 'difficult' patients: Patients labeled or perceived as 'dramatic', 'demanding' or 'uncooperative' can blind us to their actual pathology and prevent us from getting a good history and examination.
- 7) Use checklists, mental 'checkpoints' and senior advice to prevent or minimize cognitive error.

References:

1. Croskerry P, Abbas A, Wu AW. Emotional influences in patient safety. J Patient Saf. 2010 Dec;6(4):199-205. <http://www.ncbi.nlm.nih.gov/pubmed/21500605>
2. Croskerry P. Achieving quality in clinical decision making: cognitive strategies and detection of bias. Acad Emerg Med. 2002 Nov;9(11):1184-204. <http://www.ncbi.nlm.nih.gov/pubmed/12414468>
3. Block L, Hutzler L, Habricht R, Wu AW, Desai SV, Novello SK, et al. Do internal medicine interns practice etiquette-based communication? A critical look at the inpatient encounter. J Hosp Med. 2013 Nov;8(11):63-4. doi: 10.1002/jhm.2092. Epub 2013 Oct 12.



About the Expert

I am an emergency physician in George, South Africa. My hospital serves a large rural district and I love exploring innovative ways to improve emergency care in areas that are challenged by great distances and resource limitation. My main areas of interest are ultrasound, patient safety and education. I enjoy collaborating with emergency physicians from around the world to find useful solutions for global problems.

Curated Community Commentary

By Teresa Chan MD FRCPC

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. Prior to publication, we sent this analysis to one of our community members to perform a "member check" to ensure credibility (BT).

Some pointers from the community on improving multi-cultural communications and handovers:

1. Explore the resident's point of view & context.

Unless there was a CCTV camera in the room, you're probably never going to really know what happened between Sean and his patient, but as a faculty member you probably should explore this a bit. Most respondents felt it was important to explore the perceptions of both involved parties. Drs. Walsh, Rogers, Thoma and Chan all noted that it is imperative to listen to what the resident (Sean Peters) had to say about the situation. Dr. Rogers wisely noted that "... sometimes patients "split" the providers and give different stories" while Dr. Thoma stated that until the resident has had an opportunity to explain any explanations will be as flawed as the assumptions they rest on.

As an outpatient geriatrician, Dr. Michelle Gibson raises a point that there may be some inherent cultural biases that may occur that lead to scenarios like this one. She notes the response the resident, Dr. Peters, displays may be a symptom of a bigger underlying problem with the 'hidden curriculum' (i.e. he may act a certain way because he have seen others act a certain way around patients who did not turn out to have a "legitimate" injury, etc..)

2. Provide the opportunity to reflect back... it may provide you a window into their world.

Most respondents brought up that as an educator you should ask the resident what his perceptions of the interaction were. Listening to the resident's perception of the situation will give you great insight into how best to approach the issue; if he shows insight, then you can discuss and debrief the 'root causes' of the professionalism transgression.

Some suggested contributing factors to this breach of professionalism were:

- Compassion fatigue
- Depression
- Substance Abuse
- Counter-transference
- "Attribution error"
- Personality Conflict
- Problems outside the workplace (i.e. relationship issues)

3. Don't shy away from the feedback

Every mistake or problem in training gives us the chance to feedback and improve, so many respondents felt that this provided us a unique opportunity to provide constructive guidance and feedback to the resident (Dr. Peters), but more importantly, it allows him to encounter this problem now as a trainee. As Dr. Nadim Lalani notes: "This interaction was a gift from the ER gods. There's only one way to learn some skills in life. Mistakes like this offer the R3 an opportunity to learn and change."

Feedback is important, and as Allan McDougall (a social science researcher) highlights, is often highly shaded by our "culture of training". He describes the work of Watling et al. (1), which he felt was relevant to this issue around providing feedback:

"...feedback is only effective insofar as the receiver considers the provider to be credible and constructive. Further, definitions of credibility and constructiveness vary according to the learning culture (e.g., a music teacher may be highly critical of a student's posture, but that type of directness is valued in music; while a medical teacher may need to approach feedback in a different way, as we are discussing here)."

When compared to other disciplines (e.g. education and medicine), the value of feedback can be highly susceptible to cultural nuances - and Allan goes on to warn us about paying attention to our own local hospital cultures.

Curated Community Commentary (continued)

More broadly, Rob Rogers made a bold but important statement:

"I would emphasize that we owe it to our learners to keep track of this behavior and not dismiss it as an isolated event, unless it really is. This might require discussing with the program director, etc. We owe it to our patients and our learners to make sure we are doing all we can to train competent professionals. Too many times we dismiss such isolated events and never follow up. Learners with significant issues can 'slide under the radar' for quite sometime if we don't stay on top of things."

4. Remember the Patient

In clinical teaching, patient care is paramount. Many respondents suggested that it is very important to have Dr. Peters apologize for the situation. As such, several esteemed respondents reminded us that it is important to arrange for Dr. Peters to apologize to the patient. Of course, this would necessitate that Dr. Peters agrees (or at least accepts) the patient's version of proceedings. In any event, empathizing with the patient is important – and this may be an opportunity for you to role model how to deal with this type of situation.

Dr. Michelle Gibson writes about her approach to this:

"This is the biggest learning opportunity, I think. I have asked residents to address patient concerns about encounters. We usually talk about how to approach it before hand, and then I go in and directly observe. If they do a good job of this, I make sure they

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Teresa Chan
Michelle Gibson
Tim Horeczko
Nadim Lalani
Allan McDougall
Rob Rogers
Anne Smith
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Amy Walsh

know that they handled it well. I think that it usually turns it into a very, very powerful learning experience and (in my opinion anyway...) may be the thing that is most likely to help it not happen again.

As we do not have the opportunity as Dr. Gibson has to discuss encounters again later with most of our patients, it is important to act in a timely manner during that visit.

Reference:

1. Watling, C., Driessen, E., van der Vleuten, C. P., Vanstone, M., & Lingard, L. (2013). Beyond individualism: professional culture and its influence on feedback. *Med Educ*, 47(6), 585-594. doi: 10.1111/medu.12150

About

The Medical Education In Cases (MEiC) 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.

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