

The Way We Learn: "You Can Observe A Lot Just By Watching"

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Great effort and emphasis have been placed on how we learn and how best to teach the various aspects of medicine. This is particularly so with regards to breaking bad news and communicating with patients and families. Some of my early experiences as a resident have taught me that one of the oldest and most basic methods of learning remains one of the most effective. Seeing others do things well and seeing them do things badly is a crucial and powerful method of learning.

I was interested to read Donald Smallman's article on breaking bad news in the June 1998 issue of the Dalhousie Medical Journal. It reminded me of some experiences of my own and important points about our education as physicians. We spend a lot of time in our undergraduate years being told how to listen and being sensitized to all the various "issues." Seminars in ethics, end of life decisions, and how to break bad news were peppered throughout our curriculum. None of it seemed very real, and looking back it seemed at times almost farcical. No amount of seminars, sensitization, and ethical discussion can prepare you for the face-to-face reality of having to tell someone or their relatives that they are going to die.

I accompanied an experienced staff physician who had to inform a family that their mother had died. She had been diagnosed several months earlier with leukemia. A splenectomy had been advised and undertaken a few days earlier. Unfortunately, she died in the intensive care unit of peri-operative complications. The staff physician, who knew the family, and myself, who had cared for her in the post-operative period, met them in the family room.

It always strikes me in these encounters what a dismal, cramped, windowless place the family room always seems to be. You would think with all the emphasis on "family and patient-centred care" we could do better than this.

The staff physician expressed how sorry he was. He then went on at length about how this was especially disappointing to him because, unlike most leukemias, patients with this type of leukemia usually did very well after having their spleen removed. He con-

tinued in detail about the disease and its usually favourable prognosis, and how this somehow made their mother's death all the worse. The family members listened politely, were clearly not only unconsolated but visibly uncomfortable and anxious to end the "interview."

That experience has stayed with me. I can still feel the discomfort and frustration in that small, sweaty room. I often wondered what they thought of us. Had they heard anything at all? I hoped not. I have never been in a situation where I felt so inept and uncomfortable. It was all the more difficult for me afterwards because the staff physician is someone for whom I had, and still have, great respect. Even those with a wealth of experience and knowledge can be very poor at breaking bad news. His personal disappointment and sadness had overwhelmed his ability to comfort the family.

Several months later a very ill patient was admitted to the service on which I was working. She had a large and distraught family, most of whom were in constant attendance. It was clear to us that she would not survive. The family had many questions, particularly about what would happen when she died, how it would happen, and what decisions would have to be made. In particular, they were very worried that they would have to decide when, and if, to "pull the plug." They also feared that this would mean we would not be able to "keep her comfortable."

The family clearly did not feel they could make a decision to withdraw treatment if asked to do so. Presented as they were with so many confusing choices (cardiopulmonary resuscitation, intubation, defibrillation, surgery), it seemed to me that they were now more distraught and preoccupied with the burden of decision-making than with the plight of their matriarch. The staff physician took the lead. With all in attendance he care-

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fully explained the woman's condition and grim prognosis. Then, rather than hoist the decision on the family he said they we would not perform any extraordinary treatment in an attempt to revive her. He gently explained that such efforts would be futile, cruel, and would merely prolong her suffering. The sense of relief for the family was overwhelming and clear in their faces. The burden of a decision, or the fear of having to make one, had been lifted. The woman died the next day with her sad but accepting family at her side.

I was impressed at how this simple and direct approach, which many might condemn as paternalistic, had provided such comfort. The staff physician had correctly appraised the mood and will of the family and gently taken the weight of the decision from them. Rather than paternalism, this seemed to me the best application of the art of compassionate medicine.

We are taught how to put in intravenous lines and chest tubes from those ahead from us. We learn from watching others deal with a difficult patient or an angry family member. Probably the hardest and most feared thing we have to do in medicine is break bad news. Like most things in clinical medicine, there is no substitute for experience, both bad and good. This is not to dismiss the structured sessions and the step-by-step "how to do its", but they simply cannot prepare you for the real situation. I have been fortunate to have some superb role models, and some poor ones. I have learned so much from seeing others do it well and perhaps even more from seeing it done badly. This is how we learn. As Yogi Berra said: "You can observe a lot just by watching."

AUTHOR BIOGRAPHY

Roger Baskett is a graduate of Dalhousie University. He is currently a third year resident in the cardiac surgery training program. In a former life he attended the University of Toronto, primarily for the purposes of playing Rugby, but along the way completed a masters degree in history.