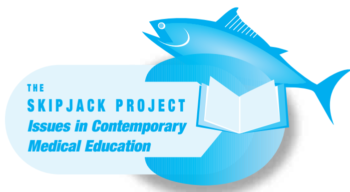

While We Were Sleeping: Encountering *Grey's Anatomy, House,* and *Scrubs* for the First Time

BY FREDERIC J. HAFFERTY, PhD, AND LYUBA KONOPASEK, MD

It is virtually impossible to work with medical students or residents and not overhear them dissect the latest plot lines and characters that inhabit today's TV doctor shows. Their fascination is nothing new. Generations of doctors-in-training have religiously tracked the interweavings of clinic, comedy, and drama depicted in programs such as *M*A*S*H* (1972–1983) and *St. Elsewhere* (1982–1988). Today's students, awash with cable and choice, can feast on new seasons and reruns of *ER* (1994–), *Scrubs* (2001–), *House* (2004–), and *Grey's Anatomy* (2005–). Although our students were functioning as cultural insiders, many of their interjections of plot and personage were lost to our appreciation (and possible enjoyment) because neither of us had any experiential knowledge about the programming, plots, and characters. It was as if these modern-day depictions of medicine had invaded medical culture while we were sleeping.

We decided to exorcise our ignorance, at least partially, by watching the first episode of three current shows (*Grey's Anatomy, Scrubs, House*). We thought we would use our newly secured knowledge to say something pithy about medical training. Our first plan was to take the ACGME competencies and "score" each episode on how these behavioral standards were reinforced or undermined by the story lines of these shows. This plan, however, quickly dissolved in the face of what quickly began to capture our attention—which we had failed to notice the first time around.

Yes, there were instances of "compassionate, appropriate, and effective" patient care, and yes, there were scenes that the respective directors obviously wanted us, as viewers, to notice (who could miss the *Grey's Anatomy* depiction of "cutthroat" interns taking bets and cheering on the failure of one of their own during his first surgery?). But then there were the myriad things that had escaped our attention until we began to compare notes. Did you know, for example, that no one "in medicine" washes his or her hands before examining a patient? We didn't—until we were well into our discussions about each program. Here we were, experienced medical educators exquisitely attuned to issues of interpersonal communication, power and hierarchies, professionalism, patient safety, and quality-of-care issues, yet each (separately and together) had missed a number of things that had "obviously" taken place before our eyes.

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The culprit, we decided, was our own socialization. We were products of a life/work world that had conditioned us to attend to certain things while ignoring others. Again, this is nothing new. All social groups can function over time because they stand on a bedrock of practices that have become so "taken for granted" that they are invisible to insiders. Socialization, after all, involves the transformation of things that are strange, foreign, morally questionable, or even repulsive to initiates into things that are commonplace, routine, morally acceptable, and perhaps even desirable to insider–members. In short, becoming a doctor means not only acquiring the physician's gaze, but also learning to "not see."

So what did we fail to notice in these three episodes? Here are some examples.

Grey's Anatomy

Twice during this premiere episode, students are manipulated by faculty to jump through particular academic hoops in exchange for access to some "forbidden fruits" (for first-day interns). The first time is when Christina Yang inquires about who will be designated the "most promising intern." The reward is to participate in the first surgery—something Yang is prepared to fight for. The "honor," however, goes to the most unlikely intern (O'Malley). O'Malley, meanwhile, is being set up for failure and humiliation. Why? The reason, according to the attending (Burke), is: "Terrorize one and the rest fall in line." Both of us noticed the manipulation, but what we missed was the tainted nature of the carrot itself (early access to an otherwise off-limits procedure) and the "obvious" risk to the patient.

The second manipulation came when a second attending (Shepherd) asks the entire assemblage of interns to help him solve a diagnostic mystery with the promise, "Whoever finds the answer rides with me...you get to do what no intern gets to do, scrub in and assist on an advanced procedure." The interns are galvanized into action. While we were quite attuned to the spasms of competition generated among the interns, we were so blinded by the nobility of the overall goal (after all, there was a sympathetic patient's life to be saved) that we failed to notice (the first time around) the totally inappropriate nature of the plum and how easily faculty can sway student learning by offering the "right" inducement.

House

Dr. Wilson, a colleague, persuades House (who is not particularly interested in caring for patients) to take on the case of a young woman by telling House that the woman is Wilson's cousin (a lie). House relents. On first viewing, we picked up

on the lie, but accepted its underpinnings as a fact of medical culture: There are limits to what you can do; you have to triage your caring; and personal connections get you the best care. The second time around, we paused and asked: Are these "facts" truly professional? Should we not invest equally in every patient? Can our patients trust us to do our best every time? Can we trust our colleagues not to manipulate us to try "even harder"?

Scrubs

For the majority of this first episode, JD is victimized and humiliated by his supervising resident (Perry). In a final scene, Perry forces JD to overcome his fears and perform a risky but life-saving procedure on a patient. "You can do it, cut him or lose him," we hear Perry bark as the cardiac monitor slows toward flatline. JD is successful and the patient recovers. Perry, for once, congratulates JD, who beams and is now on his way to becoming a competent doctor.

The first time we watched, we were elated for JD. But what if JD had failed to insert the chest tube? The tacit message is that doing is the best way to learn, and that doing trumps patient safety. Even as JD is optimistic as the episode ends, we worry about what he has internalized about the primacy of patient welfare and the importance of a safe hospital culture.

What We Have Learned

Our take-home message is simple: Take time to render problematic the obvious. Much of what goes on around us in the banality of everyday world of work is—and should remain—innocuous. To function otherwise is to be submerged in the chaos of details. As medical educators, however, we need to be sensitive to how easily our students embrace the anesthesia of unremarkableness as they quickly become overwhelmed by the bedlam we have created in a fact-riddled formal curriculum. However, improving the training of future physicians should never begin (and end) with curriculum reform. It begins by challenging that which we, as faculty, consider pedagogically beyond reproach or even necessary in the quest to create ever-better physicians. It begins by questioning that which we consider "beyond question." ❖