



# Student Blogs Express Humanism and Professionalism

BY SUSAN R. ROSENTHAL, MD

There has been a great deal written in the lay press about “bad behavior” by doctors and loss of empathy in medical training.<sup>1</sup> The results are poor communication and lack of trust on the part of patients. Ultimately, patient safety suffers. Long work hours, negative role models, and the “hidden curriculum” are all thought to contribute to this unwanted outcome. Indeed, there is literature to suggest that medical students start school feeling altruistic, sincerely wanting to help their patients, and leave school with these feelings seriously eroded.

Recently, there have been questions raised about the teaching style that will best reach our current students, the “millennium generation,” who have both different outlooks on life and different learning styles. Older methods of communication, along with views of medicine as a vocation rather than a job, now appear to be outmoded. What can we, as medical educators, do to ensure that our current students and trainees are the most empathetic and altruistic physicians possible within their own “comfort zone”?

In conversations with students over the years I have been struck by how little chance student have to “process” the experiences they are having as they move onto the intense ward-based experiences of their third year. In the busy atmosphere of the emergency room or inpatient service, they are exposed to the most horrific, poignant, painful, and joyous experiences that life has to offer, usually with only minimal preparation. Although most medical schools now have as a part of their curriculum “patient-centered medicine” courses, which introduce some clinical experience as well as small-group discussions in ethics and practice in communication skills, these experiences are very different from watching a patient die, witnessing open cardiac massage in an ER, or the myriad other traumatic events that occur in a busy hospital on a daily basis.

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## **GHHS Students Take Action**

At Robert Wood Johnson Medical School, members of the Gold Humanism Honor Society (GHHS) decided that they wanted to help ameliorate this situation, so they created the Humanism and Professionalism (H&P) curriculum for third-year medical students. The GHHS was created in order to recognize students who are exemplars of humanism, professionalism, and excellent communication and interpersonal skills. It was felt that residency program directors already were aware of academic “superstars” through membership in Alpha Omega Alpha, the medical honor society, and through class rank and the dean’s letter of evaluation (now known as the MSPE). However, there was no uniform, validated means of communicating to program directors which students would be best able to communicate with their patients, act professional, and get along well with other residents. In addition, the GHHS is a service organization, and the creation of the H&P curriculum was felt to be a service to our school.

Through a series of meetings with myself, Associate Dean for Student Affairs in the Clinical Years, and Brian Gable, MD, Assistant Program Director for Internal Medicine and a former student inductee into the GHHS, the plan took shape. We culled articles on roundsmanship, breaking bad news, personal experience of illness, unprofessional behavior, burnout, and ethical behavior from both the medical and lay literature, and posted these articles on webCT. Some articles had been written by students or residents, others by faculty, ethicists, and newspaper reporters. There were

some general articles that all students were required to read, and some articles specific to individual rotations. Each student was required to keep an anonymous, password-protected blog on webCT during the clerkship year.

All students on each rotation met once during each clerkship with myself and/or Dr. Gable in a small group. Fourth-year students were invited to join us for our discussions. Anonymous blogs (which could be seen only by students in their own class year and by myself) were printed out and were distributed to groups of three or four students. After having time to read and discuss the blogs, each group chose a member to read them aloud and discuss with the group. The students loved these sessions. With almost no prompting, these writings triggered discussion by the students about their own ward experiences. Their reactions to the often traumatic events they were witnessing were normalized by group discussions. The importance of “holding on” to their innate altruism and sensitivity to others—of not developing a carapace to hide behind when faced with death and dying—was stressed in each session. The sessions were very well received by the students. On a grading scale of 1 to 5, the sessions were rated an average overall score of approximately 4.0 (we considered this to be excellent for “touchy-feely” sessions). We also gathered some preliminary data (as yet unpublished) that indicated that this experience did indeed preserve empathy in our third-year students. The writings that we collected during this year beautifully expressed the emotional rollercoaster on which our third-year students ride during their journey through the clinical year, and the lessons they learn.

Here is one of the most “telling” examples of the effect of this experience: *“During my surgery clerkships, I happened to see a lot of lumpectomies and biopsies, spent a lot of time in the breast clinic, saw a lot of breast*

patients on general surgery. I find breast biopsies to be “boring,” simply taking out a chunk of breast tissue from a woman. No big deal. I even got to see a mastectomy, which just didn’t excite me the way colorectal or cardiothoracic surgery does. In clinic, I watched as my doctor told patients we simply had to remove some tissue because they had DCIS—no big deal.

A few times I did stop in my tracks and was reminded about how huge breast cancer really is.

One of the patients started crying because she came to my doctor for a second opinion, hoping she really did not have cancer; but my doctor couldn’t deny the path report and the need the patient had for a mastectomy. Another patient had just finished radiation and had no hair from chemo. The area from radiation was warm and had sores on it.

Sometimes you forget in the midst of learning about when to give chemo/radiation neoadjuvantly or adjuvantly, just chemo, etc. what the implications of it really is for the patient. One

time we finished a lumpectomy and tore away the sheets and I was shocked to see the patient’s face. So often in the OR we become so engrossed in the “case” we forget about the patient and this time I distanced myself to the point of forgetting that she was a person.

I read an article in a magazine, not a medical journal, about a woman’s fight against breast cancer. And procedures I blow off as “no big deal” become a big deal when you realize how frightening they can be to a patient and how much of an impact it can have on a life.... Once on a clinical OSCE, I explained to the patient how we had to give fluids and it was “no big deal.” I was told afterwards, which is very true, how fluids ARE a big deal. Fluids mean being stuck with a needle, mean not eating. Especially on surgery, where you are constantly busy to think about how this affects the patient. Reading the article made me realize how callous I had become, how matter-of-fact, how I forgot the humanity behind it all, and

how it is not “no big deal.” Breast cancer is in my family history and if one day I get it, will I see it as no big deal? As just a boring surgery compared to splenectomies and CABGs? When you personalize it, it all becomes a very big deal.”

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Certainly, we in medical education hope that all our graduates will leave medical school having internalized the fact that to each individual patient, their illness is a “very big deal indeed.” Perhaps the debriefing process, for both medical students and residents, can help us achieve this goal. ❖

#### Reference

1. “When the Doctor is in and You Wish He Weren’t,” *NY Times*, Nov. 30, 2005; “Medical Student Burnout and the Challenge to Patient Care,” *NY Times*, Oct. 30, 2008.