

Educational Malpractice

What are we to do with students and residents who don't perform to our expectations? Who don't "get it"? What is our individual and collective responsibility to them and to their future patients?

For anyone who supervises students and residents, this is a dilemma. Not a common dilemma, because usually these people can do the job—they're chosen based on scores and interviews that select for a certain ability to perform.

And for the sake of this argument, let's assume that the expectations are well defined and agreed on (something not often the case in medical education, but I am talking about behavior that would clearly be seen as out-of-bounds by any observer).

I recently completed my residency on the West Coast and daily supervised students and interns. I readily recall two troublesome instances.

"Richard" was the intern assigned to me at one of the private hospitals where we rotated during our training. He was doing a preliminary year before going into rehabilitation medicine. I started there in early December. Within 20 minutes of my arrival, Richard took me aside, saying he needed to speak with me privately: "You should know that I've been warned that if I don't do well this month, they're going to kick me out of the internship." Since I had just looked at the list of 10 patients we were picking up and knowing we were on call that night, this did not sound like good news.

I listened further. He was distraught, rattled. Richard's version of events was that he had gotten off to a rough start in July in the CCU—covering it at night alone, with a floor resident backing him up—and had developed a reputation as incompetent. He thought now that the attendings were not giving him a chance. He felt constantly "observed" and that his slightest mess-up was trumpeted around the hospital. Once a week, as an ongoing monitor, a teaching attending watched Richard take a history and do a physical; copies of all his workups were sent to the attending as well. Richard was so nervous before each observed exam, I cannot imagine he performed very well.

What was the month like for me? Long. My sympathies were mostly with Richard, but there was no denying he had some problems. He had not done much clinical in his senior year of medical school, and it showed. He also was so thorough as to border on the obsessive. He became distracted easily. This made him slow. He had trouble sorting out forest and trees—the most acute problems from the ones we could just watch. He had some irritating mannerisms—he chattered excessively, he stood too close when he talked—but quirky

personalities are hardly unusual in medicine, albeit not enjoyable.

Richard was not hopeless, but clearly he wasn't going to reach the desired performance end points of internship by the following July. He needed maybe an 18-month internship, and he needed a lot of one-on-one teaching. He got neither.

I made some attempts to help him, but I spent most of my time running the rest of the service, handling the sickest patients. We still took call every fourth night like the other teams and ran a service of about 15 patients. It didn't matter how many patients we had, he could handle only about five and I took the rest. And when I did try to go over things with him, I became frustrated. He was defensive and nervous and frequently challenged my advice. I felt out of my depth trying to handle him. What did I know about teaching anyway? It wasn't as though any faculty had ever explained to me how to teach, nor had I spent any time learning how to do it well. I'd had some good professors in medical school, but I couldn't say that I'd had consistent role models for being a good teacher. It was one thing to teach typically motivated and eager learners. Here was someone who would try the patience of a good teacher, if there were one around. There weren't any. Or if there were, they gave Richard wide berth. He was right about one thing: the attendings had all but written him off. It was obvious by the way they rolled their eyes and shook their heads when they learned he had been assigned to me.

Richard dropped out of the program in March—whether he was asked to leave or he went on his own, I never discovered.

"Peter" was a third-year medical student I had on service last fall. He was the worst student I had ever encountered. His affect tended toward the surly; he had trouble expressing himself and substantial difficulty in putting the picture together. Even at the end of four weeks, he would still list "bronchoscopy" as the problem, not as part of the plan. He left his stethoscope in his ears when we discussed a patient's examination at the bedside. He didn't make eye contact with anyone. He was eager to leave the hospital at precisely 5 PM.

After about a week, I called the dean's office, trying to find out with whom to discuss Peter's performance. After being transferred about three times and leaving messages, I was beeped back by an associate dean. I explained the situation and my concerns that this student was going to fail. The dean's sole suggestion was that I speak to Peter about seeing a psychiatrist, as perhaps he was depressed.

Peter indeed may have been depressed, but I felt quite sure that this was not his only problem. I was convinced that cognitively he did not have what it took to be a physician. Other students mentioned to me that he had made numerous attempts to be admitted to medical school and had passed

many of his basic science courses precariously. I could barely get through to him about how to present a case at the bedside, let alone suggest that he see a psychiatrist. I was perplexed that the university had such a seeming lack of interest in the affair. I felt responsible, but again, I did not have much time, with a service census of 20, two interns, and admitting every weekday. Peter met with the ward attending the requisite number of times to present his workups. I spent most of my "teaching" time reviewing those workups with him, coaching him to present in an orderly manner, but I suspected that if he were questioned closely about any abstraction, he'd crumple. I still felt I was floundering, trying to figure out where to begin to help him. He had so many different deficiencies, and he seemed to resent everything I said.

Peter did fail that rotation, as I saw him repeating it during the winter. I don't know anything about his progress since then.

The medical education system deals poorly with such "deviants" as Richard and Peter. Not that I'd say it was doing a sterling job with the "norms." The importance of medical education is much talked about, but in actuality it is low on most of the faculty's priority list. The reality is that the faculty needs to generate money through research and through seeing patients, and teaching is time-consuming and hard to do well, does not pay, and will not help much in promotion. There will always be a few souls who teach because they enjoy it and do it well, but it seems to me they cannot represent more than a small percentage of the total.

Our medical education system is predicated on having bright, malleable young people jump in and take off with minimal instruction. We throw students and interns into the pool and expect them to dog-paddle in July, sidestroke in September, do the crawl in December, and butterfly in April. Those who are still dog-paddling in November or who have to be fished out of the pool too many times cannot be assimilated. The "system" throws up its collective hands, refers the individuals to the advancement committee, and says, "It's OK because they're going into psychiatry or orthopedics" (or whatever service they're not on at the moment). We assume that the next rotation will take care of the problem. Occasionally the worry of "We may be sued if we don't pass this student" is murmured, or "How can we fail someone who has come this far?"

Situations such as I've described require some serious thought and examination in terms of what alternatives we must create. Richard probably would have been a good rehab doctor—he was thorough, he cared about patients, but he was not speedy, nor was he geared for rapid action.

I don't think Peter was ever going to "get it," but he needed the school to ask that question, directly and promptly. Just letting him go on from year to year benefited no one. He was running up a large tuition debt, and society was getting a potentially bad physician.

Some people in training need remedial help. We do give some during the basic science years, but certain problems do not surface until students face more than multiple-choice tests. And it's easier to explain the Krebs cycle than to instill clinical judgment and analysis. The clerkship and residency systems behave as if remediation is not a possibility—that the scheduling or work load cannot permit it. In reality, it's faculty schedules and hospital finances that cannot provide the time such remediation would require—hours and hours of

difficult work. The faculty spends its time stretched between practice, research, or committee meetings, and the hospital needs the house staff to give 24-hour coverage and to do a host of tasks that propel patients through the system.

Those students and interns who need help must obtain it from people who have the time and the talent to give it—not harassed residents, or subspecialty attendings who drop in three times a week. From where did the assumption come that all students learn at the same rate and that we need only "see one and do one" before we can "teach one"? Some folks need to see three or four and do five or six. And believe it or not, there are loads of physicians who will *never* be able to teach one.

The house staff endures a schizophrenic educational system—on the one hand, one is a student, there to learn and to absorb knowledge. On the other hand, one is a worker bee, an employee who still has to be on call every fourth night, do the histories and physicals for the attendings, and prepare the discharge summaries pronto so the hospital can bill Medicare ASAP. The only time I ever heard from the hospital administration during my residency was in threatening telephone calls when I fell behind in discharge summaries, which doesn't say much for our employee/employer relationship.

It was also clear to me that my education would always take a backseat to my employee duties—don't be going to the library to look up something when there are gentamicin levels to draw and endless paperwork to fill out. This issue is usually handled by a sanctimonious "The patient always comes first." This is a misleading shibboleth that confuses true instances requiring devotion to the patient—treating a fulminant hemorrhage or talking with a family about a cancer diagnosis—with tedious tasks shunted to the house staff because they are in no one else's job description and no one does them cheaper than do residents.

Isn't there a contractual obligation between the residency program and the house officer to remediate when necessary? The obligations seem often to follow a one-way flow: the house staff do the required work in a timely manner or they're jettisoned.

Why not let Richard have 18 months for his internship? Because it would throw off the call schedule? Because the system couldn't find \$11 000 for the extra six months? How many faculty members possess the time and skill to work diligently with people like Richard and Peter? And how effectively can house staff or students obtain redress for deficiencies in their instruction?

Part of the arrogance of medicine is the idea that receiving an MD degree means acquiring an instant ability to teach. Teaching requires instruction in educational techniques. Teaching takes personnel, time, and money. But when the faculty's primary obsession is whether that NIH grant is coming through to pay their salaries or whether their latest article has been accepted so they can get tenure, teaching will never get the time it deserves.

I am not sure how best to do the teaching, nor do I know who is best qualified to teach. But I am sure of one thing: the present clinical clerkship and residency system of *laissez-faire/sink-or-swim* is outmoded and amounts to educational malpractice.

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