In Your Own Words: Toward a More Perfect Union of Patient Care and Education

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Communication with patients and their families is a challenge for busy trainees. It is essential, however, that these trainees learn effective communication skills to create rapport with their patients, to add to their own satisfaction in caring for these patients and to use these conversations to constantly reassess their plans for treating their patients. Reflecting on the plans for and the outcomes of the care of their patients will also significantly enhance the educational value of the participation of trainees in this patient care, while simultaneously improving the care of both their current and their future patients. Finally, gaining facility in elaborating on their plans for and the delivery of patient care will help trainees become more articulate and thoughtful practitioners.

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> Every system is perfectly designed to achieve exactly the results it gets. [1]

One goal of every training program in any clinical discipline should be to create an optimal "learning organization" while also optimizing patient care. In his book entitled "The Fifth Discipline: The Art and Practice of The Learning Organization," Peter Senge writes that a learning organization has 5 main features, which are systems thinking, personal mastery, mental models, shared vision, and team learning [2]. These characteristics, in our opinion, form the basis of the environment of an optimized Thoracic Surgery training program. They also are more than a bit reminiscent of most of the 6 competencies on which the Accreditation Council for Graduate Medical Education (ACGME) has been focused in recent years. Thus, the goal of every resident training program should be both to facilitate making the learning environment contribute to a good patient care environment and, reciprocally, making patient care activities contribute to the learning environment.

While it was assumed when the duty-hours regulations were implemented in 2003 that patient safety would be improved and that resident well-being and resident education would likely also be improved, it is far from clear that these goals have been achieved. In fact, the available data now suggest otherwise. In fact, a recent study that reviewed 376 million patient discharges concluded that "the lack of consistent patterns of change suggests no measurable effect of the policy change" on patient safety indicators [3]. One of the very important challenges of the current residency training environment that may help explain this somewhat unexpected finding is the multiple, sequential patient handoff reports which must now occur. A recent study of handoffs found that less than 50% of the information was being passed on successfully [4]. It is hard to imagine that anyone would consider that degree of accuracy optimal or even satisfactory.

After a combined 6 decades dedicated to participating in postgraduate surgical education, both on the front lines and in our national organizations, we have had some experiences and made some observations that may be helpful to those trying to optimize education and patient care in Thoracic Surgical training programs. We will address some of the challenges, suggest some potential solutions, and outline the putative benefits of focusing on helping our trainees to communicate, reflect, and elaborate in order to optimize both the care of their patients and the education of themselves and those around them. Each of these processes requires that our trainees be able to effectively put things in their own words.

Enhancing Patient Care and Education Through Communication

Communication with patients and families is always a challenge for residents on busy surgical services. It is, however, essential for residents to learn the skills of communicating effectively with those for whom they are caring. Our trainees must learn to articulate effectively to patients and their families the plans, risks, benefits, and expectations of the treatment being proposed. This skill is certainly part of the professionalism competency, one of the 6 essential competencies for which we are required to evaluate our trainees. However, as colorfully noted in an essay in a recent issue of the New England Journal of Medicine, entitled "Don't Learn on Me," [5] one of the challenges in this realm is the nearly universal sentiment of patients and families that they would rather not have trainees involved in their care. Recognizing this feeling and not having a good strategy to counter it, many

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residents consciously avoid the discomfort of encountering their patients and their families. We have found that a useful way to approach these situations is to coach our residents to introduce themselves by saying "I am Dr Y, and I work with Dr X. He (or she) has asked me to help him (or her) with your care." This approach to an initial encounter has the virtue of immediate identification of the trainee and the trainee's relationship with the responsible faculty member. Furthermore, it establishes the fact that the faculty member obviously values the resident's participation in the care of the patient, having explicitly solicited the involvement of the trainee.

Another useful, and efficient, strategy for establishing rapport with a new patient, as well as the family, is to ask the patient what she or he wants to do when she or he is well again. First of all, one has immediately inferred the expectation that the patient's care will likely be safe and effective. Second, this question allows the patients to divulge something important about themselves. Furthermore, it has been our observation that patients and families expect a certain amount of conversation with their healthcare providers. Why not make this initial conversation be not only about the plans for their care but also address what they see themselves doing when they have recovered? Doing so will certainly begin to create a comfortable rapport.

There is, however, an additional benefit to establishing this kind of rapport with the patients and their families, which was well encapsulated by Atul Gawande in an address to the Association for Surgical Education when he lamented the loss of the relationship his father, also a surgeon, had had with his patients when he was a resident in an earlier era, noting how "he could not help but feel personally invested …he was the doctor, not the technician, and he knew that meant something important… ." Dr Gawande goes on to say that "unless we find a way to revive the relationship between resident and patient, and thus the dedication and purpose that fuel the imagination, the quality will not be what it was, let alone what we want it to be" [6].

Thus, we believe that helping residents learn how to talk effectively and comfortably with patients and their families in their own words is essential in caring for their patients and is equally essential to caring for the residents themselves.

In addition, we believe that there are noteworthy benefits to be gained from articulating aloud plans and risks with patients and their families. These benefits include the reality that the trainees will be more likely to recognize some aspects of the anticipated procedures during these conversations that may well benefit from further contemplation and potential modification of the plans.

Enhancing Education and Patient Care Through Reflection

> Whatever else a surgeon is, he is an internist and something more, not something less.—Francis Moore, MD [7]

Another arena in which it is important to use one's own words is in writing about one's patients, both by writing in the medical record and by writing out one's reflections on what one has done and learned. It has often been said that writing in the medical record is one of the internist's most valuable tools, as doing so not only communicates the writer's thoughts but the act of writing also itself promotes clear thinking. We are reminded of Dr J. Willis Hurst's colorful essay on medical record keeping entitled "Garbage in the Living Room" [8] in which he memorably makes the point that if one's notes are sloppy and disorganized, it is hard to imagine that one's thoughts are significantly less so. Or, consider the recently released CIA Style Manual [9], which states "good intelligence depends in large measure on clear, concise writing. The information that the CIA gathers and the analysis it produces mean little if we cannot convey them effectively."

> There is no more difficult an art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language.—Sir William Osler [10]

It is our observation that most preoperative and progress notes, especially in the era of the electronic medical record (EMR), bear more of a resemblance to an "unsolved" Rubik's Cube than to one that has been put into the final, organized form. Using a problem-oriented approach as advocated by Dr Hurst or a systems-based approach, as is commonly used in writing critical care notes, seems infinitely preferable to the jumble of most notes making their way through the modern EMR. As Edward Tufte notes in his book Visual Explanations [11], "clarity and excellence in thinking is very much like clarity and excellence in the display of data. When principles of design replicate principles of thought, the act of arranging information becomes an act of insight. Since such displays are often used to reach conclusions and make decisions, there is a special concern with the integrity of [both] the content and the design."

We believe that even the most senior residents should be writing notes, in their own words, in the medical record, at the very least as a preoperative note. This recommendation has 2 important benefits: to outline the residents' thought processes to the rest of the medical team caring for the patient and to clarify and, perhaps, expand, for themselves, their own thoughts and plans.

> I write for discovery.—Joe Henry, Song Writer [12]

We also believe that residents should write for discovery and reflection, particularly after participating in surgical operations. Dr Frank Spencer, in The Gibbon Lecture presented at the American College of Surgeons meeting in 1979 [13], described how he dictated a note of reflection to himself about operations he had done as soon as he had finished dictating the actual operative note, a habit he notes that he maintained throughout his career. However, most residents do not have easy access to a transcriptionist, so we like to recommend that residents develop the habit of writing reflectively in a "black book" such as those sold by the Moleskine Company (http://www.moleskine.com/us/). These black book thoughts will not only solidify the lessons of the day but will also, nearly invariably, prompt additional questions