

## AN ATTENDING'S RESPONSE

## Look not to Fairy Tales but to Yoda

Chayan Chakraborti, MD

*Dr. Chakraborti is a member of the SGIM Forum Editorial Board and can be reached at cchakra@gmail.com.*

**B**ased on the natural history of the 2003 ACGME duty hour restrictions, the new duty hours are ostensibly here to stay. This change reflected the larger issue of time pressures that have been plaguing the institution of medicine for years, if not decades. To be clear, I am referring to the extra time residents theoretically have due to caps on patients and not to the amount of time residents get free from patient contact.

If the restricted duty hours have not resulted in increased medical knowledge, this conversely implies that residents have not performed worse in knowledge-based assessments. One could point to the ineffectual reforms. However, there are other players at the table. With the ability to concentrate on fewer patients, sure, the house staff may have more time, and it has been implied that residents will have more time to study, read, or even (vaguely) learn. Is this really how medical knowledge increases? Are there other skills that are not being captured adequately that may be improving? Perhaps what has not kept pace is the ability of *faculty* to use this extra instructional time effectively.

The obvious rejoinder is that by reading more on their patients, residents will increase their knowledge. But I submit that this will only get someone so far. There are, I believe, other potentially more effective uses of the extra time such as watching faculty model good skills, including critically appraising a potentially practice-changing journal article; debrief-

ing the team on a patient encounter that went poorly; or observing house staff as they perform bedside patient evaluations.<sup>1</sup> To do this effectively, the teaching skills of faculty need to be developed.

Teaching ability is a bit like having style; everyone thinks they are good at it. Now I don't pretend to have style, but I have been working on my teaching ability ever since I taught high school in the mid-90s. That doesn't mean I'm necessarily any good—only that I am willing to work at it. Ward attendings need to find ways to make better use of this extra instructional time rather than leaving it up to the resident to use the time “wisely” or “better.”

The example of the resident going off-duty to interact with a consultant illustrates problems not just with the system but also with educational practices. Things change, and as the practice of medicine changes, so should the aspects relevant to medical education. Reform is afoot (or at least, should be). Perhaps what needs to occur is a reassessment of what the medical education endeavor should value. A short off-the-cuff list might include training on:

- Patient hand offs
- Communication skills (with other health care providers including allied health; heretofore, communication skills have focused on patient-physician interactions)
- Inter-professional team-building
- Good transitions of care
- Prevention of medical errors

- Training mentors to be better teachers

Finally, “shift” does not have to be a bad word. This became a part of the cultural lexicon of general medicine housestaff training in 2003, when duty hour restrictions and patient caps were first introduced. The need to emphasize new skills and new aspects of professionalism was not recognized at the time. These need to be *taught and modeled*. Duty restrictions and caps were handed down, leading to some unintended consequences. Now we bemoan the house staff's lack of professionalism as if they (as trainees) were just supposed to “get it” despite the fact that medical educators have been struggling to teach the inherently nebulous concept of professionalism for quite some time. If blame is to be apportioned, I believe that mentors and educators stumbled in setting certain standards and not providing the support necessary for success.

If fairy tales teach anything, it's that heroes rarely go far without guides to show them the way:

*Incomplete was your training.  
Not ready for the burden were you.*

— Yoda

Episode VI: *Return of the Jedi*

## References

1. Verghese A, Brady E, Kapur CC, Horwitz RI. The bedside evaluation: ritual and reason. *Ann Intern Med.* 2011 Oct 18; 155(8):550-3.

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