Teaching Communication and Professionalism Using a Popular Medical Drama

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A wealth of material depicting medical trainees is featured regularly during prime time television (i.e., “Scrubs,” “ER,” “Grey’s Anatomy,” and “House”). Medical dramas have come under serious scrutiny, with much of this examination centered on their potential influence on public perceptions of the medical profession and the delivery of health care.1–3

In an effort to accurately represent real-world medicine, one major newspaper in our region, The Los Angeles Times, has a periodic column in the Health Section that analyses the accuracy and reality of medical dramas in their portrayal of various medical conditions, treatments, and procedures. Some have opined that the accuracy of these dramas is high even in the presentation of rare medical cases. Other analyses have focused on the portrayal of physician interactions with patients, the personal lives of physicians, and relationships within the medical hierarchy. Most charged have been depictions of sexual boundary violations.

While these programs are controversial, in part to attract and maintain viewer interest, they are readily available as an adjunct to educational discussions. There are several advantages to the use of these dramas in teaching. Medical students and residents may already be periodic or regular viewers. Therefore, the use of medical dramas in a teaching context may be likely to capture and maintain trainees’ interest. Parallel to family medicine training and practice, continuity of the television series allows us to see these characters struggle, grow, and make hard choices.

McNeilly and Wengel4 reported on their use of clinical vignettes from the medical drama “ER” to teach communication skills and psychotherapy to medical students. They specifically used the vignettes to illustrate encounters with extremely emotional or personality-disordered patients. They also used the material to examine the psychological meaning of these encounters and students’ ability to tolerate emotional exchanges with such patients.

Medical dramas contain a wide gamut of professional behavior, dilemmas, and ethical issues. French1 stated that “Grey’s Anatomy” portrays many salient and sacred physician characteristics and practices in a positive light (dedication,
altruism, humanity, professionalism, etc).” He also acknowledged the show sometimes falls short in medical ethics and professionalism.

Desiring vignettes depicting physician communication and professional challenges, we selected one episode from “Grey’s Anatomy” that we believed had the greatest potential to stimulate discussion on several fronts. This particular show demonstrated both inappropriate communication and professional behavior desired.

The episode selected (Season 1, Episode #6, “It Tomorrow Never Comes”—“Grey’s Anatomy,” DVD Set, Season 1) contained the major theme of a patient seeking treatment late in the course of a serious life-threatening condition. Physician thoughts, feelings, and behaviors that arise from these situations are demonstrated. Various levels of interview skills such as obtaining informed consent and talking with family members are also highlighted.

Our learning objectives for this presentation included (1) to explore reactions to patients “late to treatment,” (2) to practice and gain more comfort in responding to questions about life-threatening situations, (3) to discuss ways to manage personal feelings in response to difficult situations, and (4) to manage appropriate informed consent with vocal family members.

Listed below are the counter times and scene descriptions for five clips we used, as well as discussion questions.

10:47–11:56: 43-year-old female patient with an enormous tumor is undergoing a CT scan. The resident is reassuring and friendly. [Elicit an assessment on the resident.] However, while the patient is in the chamber, she overhears the resident calling her “warped” and criticizing her for not seeking medical attention sooner. [Discuss issue of talking about patients anywhere but behind closed doors. How would you react to this resident’s comments if he were talking with you about the patient in this manner? What should be done to remedy this situation? What would you advise the resident to do?]

11:57–12:34: Another resident is obtaining a history from the patient’s mother. The mother describes at first thinking that her adult daughter was just putting on weight. She stresses, “I tried to get her to go to the doctor.” The resident appears disgusted and ends the encounter by saying, “The right thing to do would have been to call a year ago.” [Might you have been thinking what this resident blurted out? What would be a better way to respond to the mother?]

16:06–17:52: Surgery is being discussed. The patient asks, “Am I going to die?” [How do we answer these questions?] The patient declares that she does not want the offending resident at the surgery. His attending asks him about it, and he realizes the patient heard his comments during the CT scan. The attending talks about risks of lawsuits. [Should this be the most important concern of the attending? What else might the attending have said?]

14:04–15:11: The radiographic films are being reviewed and discussion ensues. The cardiothoracic surgeon and neurosurgeon cannot agree on an approach to care. A senior resident asks, “Why would anyone wait so late unless they wanted to die?” [How would you feel about proceeding with treatment with someone so far advanced? Have you ever waited longer than you should have before seeking out medical care? Can you imagine a situation where you might wait before seeking out treatment? Have you known of a family member or friend who did?]

18:04–19:05: Another resident is talking with the patient prior to surgery. The patient tells him, “You do not have to talk to the fat, nasty, tumor lady,” referring to herself. The resident asks her, “Why did you let it get so bad?” She explains her history with hospitals and people dying. [Why do you think it is so difficult sometimes to be upfront about asking the most basic questions? What thoughts/emotions may be barriers to asking, “Why?” How does knowing this history change your perception of the patient?]

Our trial with this material generated interest and considerable discussion. Residents made comments as clips were shown, and all members of the audience participated. Their thoughts and responses led to further questions, for example, do you think the patient’s obesity played a role in the physicians’ reaction to her? Would reactions have been different if the patient was a male?

In evaluations completed immediately after the conclusion of the presentation, residents (n = 9) rated the use of the medical clips to stimulate interest and discussion as “4” or “5,” with “5” representing “extremely helpful.” All residents surveyed endorsed that they would like to see such clips used in the future and rated use of the clips as adding to their appreciation of the topics. Other comments as to how use of the clips was helpful included the following: (1) Set the stage quickly, (2) Got me to thinking about my own style, (3) Stepping back and analyzing our field as humans, our natural tendencies, etc. For improvement, one resident suggested that we restate goals of the session at its conclusion.

We enjoyed experimenting with this material. It set an immediate clinical stage for teaching and discussion. Since these shows depict residents and attending physicians from various surgical specialties such as OB-GYN, orthopedics, and emergency medicine, they may be of special interest to our colleague educators in these arenas looking for innovative teaching approaches.
As programs grapple with how to best teach medical communication and professionalism in especially challenging clinical situations, dissemination of teaching ideas is relevant. Perhaps a bank to collect tested material could be created in line with the sharing goal of the Family Medicine Digital Resource Library (FMDRL).

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References