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See One, Do One, Teach One

By Lauren Gambill

My phone screeches with the loudest, most obnoxious ringtone I could find. I set it that way to make sure it wakes me up when someone calls. It is 1:35am, on my second overnight shift as a pediatric hospital attending physician. In stark contrast to the shrill ringtone, the humble voice of my senior resident, Eleanor, is on the line.

"Doctor, I'm sorry to bother you. May I discuss a patient with you?"

"Absolutely!" I say, a little too enthusiastically. I am trying to pretend that I was not asleep. I am not exactly sure why. It is expected for the attending to sleep some at night. Nights are when residents are given the rare opportunity to practice autonomy, transforming from medical students into physicians, quietly, while the rest of the world sleeps. My job as their attending is to be present for guidance and support but not to hover or micromanage. As an attending physician, training new doctors, I teach by practicing medicine through their eyes, ears and hands.

When I applied for medical school, I did not realize to what extent being a physician is being an educator. As physicians, we are not explicitly trained to teach. I know embarrassingly little about educational models or theory. However, through my every action, I am teaching the science and the art of medicine.

"See one, do one, teach one." This mantra has been repeated to me many times through the years. Though arguably antiquated or even a potentially dangerous model, it remains the core of physician training.

I remember the first time I heard the expression. I was a medical student. My one-month-old patient needed a lumbar puncture. The supervising physician asked me if I wanted to do the procedure. My heart raced as I explained that I had only ever seen the procedure performed once. I was not qualified to stick a needle into the spine of an infant.

"See *one*, do one, teach one."

She handed me the wrapped box of supplies.

After I finished the procedure, the attending removed her gloves and slipped out of the room while I was cleaning up. "Next time, you teach one." she said without looking at me, and disappeared back to the call room.

> *Studies have shown that 28–42% of residents feel inadequately trained to safely perform various practical medical procedures... alone for the first time.*[1]

On the phone, Eleanor explains her concerns about a patient on the floor. He is an eight-year-old admitted for an infection. He had been doing well on antibiotics, but he is having new abdominal pain that she cannot explain.

"Am I missing something?" she asks.

In my head I am wondering the same thing, "Am I missing something?" Her thought process is sound. She has examined the patient and tried the initial steps that I would try. We discuss abdominal pain and her plan for moving forward.

"I do not think so. I think you are doing all of the right things. Do you want me to come see the patient?"

"No, Doctor. Not yet. I would like to try those interventions and call you back if things do not improve."

I hang up the phone and stare at the wall. I review the story from the resident in my mind and pull open the chart on my computer. I wait. This is the most difficult part for me as a new attending. In this moment, I am acutely aware of the tightrope I must walk, finding equilibrium between ensuring the very best care and safety for my patients, while also allowing space for the next generation of doctors to develop the critical thinking skills they will need to care for patients for the duration of their career. This balancing act is my intertwined obligation to heal and to teach. It has not taken me long to realize this dance is guided by instinct, as often as it is guided by science. Tonight the science is telling me everything is ok while my instinct is not so certain.

When my phone rings a second time, I head out of the door before I answer. The patient is decompensating.

> *Clinical gestalt is the theory that healthcare practitioners actively organize clinical perceptions into coherent construct wholes. This implies that clinicians have the ability to indirectly make clinical decisions in absence of complete information and can generate solutions that are characterized by generalizations that allow transfer from one problem to the next. In essence, clinical gestalt is pattern recognition and is characterized as a heuristic approach to decision-making.*[2]

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At his bedside there are two calm nurses working quickly. From across the room I can see the jugular vein in the patient's neck bounding, a sign of impending cardiovascular collapse. He is unconscious, moaning and gasping for air.

"Call the PICU."

"Yes doctor." My resident quickly walks out of the room.

At the bedside, I silently repeat the mantra of any medical emergency, "airway, breathing, circulation." I consider my options. Oxygen, IV fluids, antibiotics, labs, X-ray. This child needs more. He needs medicine that I cannot give on this unit.

Turning to the mother, I finally introduce myself. I am certain to her it feels like an eternity since I walked into the room.

"I am the supervising pediatrician. It looks like your son has gotten much sicker. I am not exactly sure why, but we are calling the ICU doctors to help us."

She nods and mouths "OK," but does not make a sound as tears began rolling down her face. A mother always knows when her child might be dying, even before anyone explicitly says the words.

When the Pediatric ICU team arrives, I stumble through an explanation. I do not have good one. He was stable just hours before.

The team observes the boy, reviewing the vital signs, watching his body struggle. Away from the mother, the ICU attending turns to me and whispers, barely audibly,

"He looks like shit."

As the team whisks him away to the ICU, I linger. I could follow him up to the tenth floor, but I hold back. He is in good hands. The Pediatric ICU is a place where medicine can restart a lifeless heart, open closed lungs, stop a seizing brain and clear an infection, sometimes all within the same small body. It is also the place where some days, despite everyone's best efforts, and for no clear reason, medicine cannot do any of those things. A place where "there is nothing more we can do," followed by the unmistakable scream of a grieving mother.

The first time I heard this penetrating scream I was twenty-eight years old. I was a second year resident working in the Pediatric ICU. A 3-year-old little girl in the care of a baby sitter had pulled a large television set on top of herself. Her head injury was not survivable. By the time her mother arrived to the hospital and ran into the ICU, drenched in sweat from the July sun, her daughter had been brain dead for nearly an hour. I was standing a few feet away when my attending looked into the eyes of this mother, and quietly told her that her baby girl was never coming home. "I am so sorry" she managed, as tears rolled down her face. Time stood still as I struggled to maintain my balance through the scream that shook my soul. There are moments in medicine that change you forever.

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> *Rites of passage both nourish and consume those who enact them. A rite is not only the bridge over which folks pass; it is the troll beneath, its stomach growing to devour all who cross. Rites bridge; rites threaten to consume. We don't get to cross without paying a troll. There is good reason to weep at funerals and weddings. Having passed through a phase, we can't return.*[3]

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The resident and I stand in eerie silence. Moments before, this hallway was a flurry of activity and people. Now, there is no evidence of what just occurred. Hospitals have a certain magic in this way. During an emergent situation, people flood into a room, working in calm chaos. Once the situation has abated, whether through stabilization, transfer, or even death, the room is quickly cleaned and the team scatters. Nurses and physicians run to care for other patients and document their actions, disappearing as quickly as they had arrived. The memory of the event and the patient is swallowed into the hospital walls.

Eleanor is standing beside me. She is silent, trapped within her own mind, asking herself what she could have done differently. Her self-doubt is palpable. I want to acknowledge this doubt.

As her attending physician, it is my role to tell her that, medically, she did everything right. Children decompensate quickly. She watched him closely, changed his medication appropriately and called for help as soon as she needed it. It was also my job to validate the fear and the heartbreak of seeing your patient worsen despite your best efforts. When something unexpected happens to a patient who placed their life in your hands, it shakes you to the core. We wonder if we are smart enough. Fast enough. Good enough.

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> *Impostor Syndrome is characterized by chronic feelings of self-doubt and fear of being discovered as an intellectual fraud. Despite evidence of abilities, those suffering from Impostor Syndrome are unable to internalize a sense of accomplishment, competence, or skill. Overall, they believe themselves to be less intelligent and competent than others perceive them to be. A 1998 study by Henning et al. found that among medical, dental, nursing, and pharmacy students, 30% scored as impostors. Within this population, Impostor Syndrome was found to be the strongest predictor of general psychological distress.*[4]

The day I started my surgery rotation as a third-year medical student, I eagerly learned everything I could about my first patient, an elderly woman with stage 4 ovarian cancer. She had just arrived in the emergency room. She had tumors all throughout her body and her organs were failing. Because of her organ failure, fluid constantly accumulated in her abdomen. As her abdominal girth increased, she found it excruciatingly difficult to breath. To alleviate the symptoms of suffocation, she visited a clinic each week, where a needle was inserted into her abdomen and liters of bright yellow fluid were drained out of her body and into glass jars for disposal. Today in clinic, this needle had slipped and perforated her bowel.

As I relayed what I had learned about the patient to the surgery chief resident, Miguel, he nonchalantly explained to me in his thick Spanish accent that she needed emergency surgery or she would certainly die tonight. “But because she is a terrible surgical candidate, even with

surgery, she probably will never wake up." Still, her family had decided to move forward with the surgery.

Miguel sent me and the sleep deprived, frazzled intern, Gael, to insert a nasogastric tube through her nose and into her stomach. This tube would be used to suction out anything in her stomach. It should make her feel a little better while we wait for the OR to be ready, Miguel explained. In the room, I talked to the patient softly while Gael fumbled with the tube, trying to make sure everything was connected correctly. As he inserted the tube into her nose, she coughed, closed her eyes and stopped breathing. The monitor began to blare loudly as we tried to wake her. Her heart stopped. Gael started chest compressions, as nurses, physicians, and pharmacists flooded in. My first patient was pronounced dead within the hour.

After the dust settled and everyone dispersed, I looked to the chief resident for counsel. I silently wondered "Did I miss something? Should I have seen something and warned them not to place the tube?" In retrospect, I know there was nothing I, a naive medical student, could have done differently to change what happened that day. Rather than say this to me though, Miguel turned to me and Gael, now noticeably pale, and said "Let's go to the doctor's lounge. There are cookies there." As we ate our cookies and discussed the next scheduled surgery, I tried to mirror Miguel's calm and collected demeanor. This was how doctors are supposed to act.

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> *The "hidden curriculum" refers to medical education as more than simple transmission of knowledge and skills; it is also a socialization process. Wittingly or unwittingly, norms and values transmitted to future physicians often undermine the formal messages of the declared curriculum. The hidden curriculum consists of what is implicitly taught by example day to day, not the explicit teaching of lectures, grand rounds, and seminars.*[5]

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This is not your fault.

Five words. They were true, but I never said them.

"Let's talk about the new patient," is what I blurted out instead.

"Yes, Doctor."

The intern joined us and relayed the history she had obtained from a patient who had arrived earlier in the evening. We did not necessarily need to discuss or see this new patient at this moment, but it was all I knew how to do.

We walk down the hall to the room of a small girl who was not particularly excited to see us. At the bedside, I lean in and I close my eyes as I listen to her heart. A strong healthy rhythm. I listen for far longer than I need to, slowing my breath and inhaling the comfort of the steady

beat. When I finally look up, Eleanor is standing at the bedside watching me, waiting for me to prompt her to move forward. She needs to complete her exam on this patient as well. I had nearly forgotten we had come together.

I step back and review the plan of care with the patient's mother. "I think she will be back to normal in a few days," I reassure her. She looks down and smiles at her daughter. As Eleanor moves forward to examine the patient, I slowly walk out of the room, and I do not look back.

*Identifying details changed to protect privacy of patients and physicians.

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