The Value of a Gut Punch

It was the last day of my rotation on the inpatient hematology service. As a third-year resident in internal medicine, I felt secure in my knowledge and skills but unsure of the direction I wanted my career to take after residency. As I wrapped up the day's work, the pager on my hip buzzed: the attending wanted to give me feedback on my performance during the time we had worked together. I went to the call room and returned the page. I was not prepared for what she said.

I had stayed for residency at the same institution where I had been a medical student, and by chance I had been assigned to this attending before, in a small group for a clinical skills course during my second year. She had gotten to know me well during those sessions when we went to the hospital to see patients together so that my classmates and I could practice our histories, physical examinations, and patient presentations. She set high standards that the other students and I sometimes struggled to meet, but during my third-year clerkships, I realized I had her to thank when faculty members praised my clinical skills. I considered her tough but fair, so when I called her for feedback, I expected some mild criticism alongside the vague praise I had gotten from other faculty.

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What I got instead felt like a punch to my gut. When she compared my performance as a resident physician with her recollections of me as a student, she said, she felt deep disappointment. Specifically, the obvious joy that I had taken in patient care as a student, she found itself drawn toward a career in primary care. I remember the burning shame and embarrassment I felt in that moment more than what I said in response. I think I managed a fumbling explanation of some of my decisions and actions before thanking her for her time and ending the call. But I can clearly recall my sense of profound disorientation as I walked the wards for the rest of that day. The ground seemed to shift beneath my feet as I questioned my self-confidence. As time passed, my thoughts about my negative feedback went through stages. First came denial: "No, she's wrong. I did just fine. My patients did well. I'm a good doctor." As it slowly dawned on me that some of what she had said was true, I reached for self-justifying rationalizations: "I'm burned-out. I just didn't like that rotation. All my other feedback from faculty has been really good." Eventually, though, I couldn't escape the full weight of what she had told me: I was not what I had set out in medical school to become. I had failed.

The uncomfortable insight forced me to reevaluate my priorities and even my vocation itself. I had started residency planning to subspecialize, but as I discerned my thoughts and feelings, I realized I enjoyed medicine most when I had a long-term relationship with patients, especially in clinic. Every specialty cultivates patient-physician relationships, of course, but I personally found myself drawn toward a career in primary care. I felt challenged and edified by the responsibility of having patients consider me "their doctor," the one they would turn to in times of need and vulnerability, and this focus on the patient-physician relationship being central to medicine also aligned with my interest in ethics. Ultimately, I decided to pursue academic primary care and medical ethics, and I have not regretted that choice.

Nevertheless, I have thought about this feedback many times over the years because I am now a faculty physician who often delivers feedback to students and residents. I frequently find myself giving the same kind of vague praise that I had received. Of course, there are plenty of systemic explanations for why it seems that most trainees are rated "above average," as though we were teaching in Lake Wobegon. The same structures that interrupt continuity of care for patients also undermine continuity of instruction for students and residents. The frequent handoffs between attending physicians in the hospital, coupled with a training system that encourages hypermobility, forcing students and residents to move to a new setting every few weeks, make it unlikely that a trainee will work with the same faculty member multiple times, let alone encounter a mentor who encourages the trainee's professional growth over the course of many years. In my case, however, the continuity I had with a faculty member gave her the necessary
perspective to see how I had changed for the worse and point out my specific shortcomings.

As faculty, we are also taught to cushion the blow when a student or resident needs to be told how to improve. We sandwich criticisms between compliments, for example, as a way to spare the trainee’s feelings. This attentiveness to how trainees might receive negative feedback conforms with the increased emphasis on well-being at medical schools and institutions, partly as a way to respond to the crisis of physician burnout and mental health concerns. Yet it also perhaps encourages a kind of consumeristic mindset within medical education, in which the trainee as “customer” is always right. A bad evaluation might lead to a complaint or appeal and meetings with the medical school leadership: better, then, simply to say something encouraging and let the trainee move on to the next attending, along the conveyor belt toward graduation.

As I reflect on my own experience, I can’t help but conclude that faculty need to retain the art of giving some negative feedback at appropriate times, when a student or resident needs to hear it. No one wants to return to the stereotypical bad old days of the last century, in which haughty attending physicians might belittle students and residents without end. As the welcome attention to wellness reminds us, the system needs to promote overall well-being of learners even in the way formative feedback is delivered.

However, as members of a profession expected to regulate itself for the public good, we also need to assume responsibility for helping trainees surpass being merely “good enough.” If we prove unwilling to name the professional shortcomings of trainees and help them improve, how can we expect them to develop the habits of right action, otherwise known as the virtues, that are necessary to become excellent physicians? No doubt many will do so on their own, but others may need the kind of tough love that compelled me to reflect and improve. In short, physicians need to foster the kind of moral community in which the virtues can be preserved, exemplified, and handed on, and their contradictory vices identified and rooted out. In turn, teaching institutions need to match this commitment by implementing reforms such as increased salary support for medical education. Such policies might provide faculty physicians sufficient time away from clinical duties to observe their trainees’ progress and develop long-term mentoring relationships in which helpful feedback, both positive and negative, can be given and received. This notion of the medical profession as an ethical community in which we support one another’s clinical and moral development might also better inoculate physicians against burnout, which so often sets in when we feel isolated.

For my part, although I would not have believed it at the time, I am now grateful for the attending physician who was willing to give me the gift of stern criticism at a crucial point in my life. Had she simply passed me on to the next attending, I cannot say whether I would have made the same choices afterward or rededicated myself to developing strong relationships with patients. She saved my medical career and, perhaps, my life. To that attending physician, then, I can only say: Thank you for knocking the wind out of me. I needed it.

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