LETTERS TO THE EDITOR

Medical Student Name Tags

To the Editor:—The innovative study by Silver-Isenstadt and Ubel on medical student name tags, in the November 1997 issue of the *Journal*¹ started to answer the important question, “How do patients interpret the titles on medical student name tags in regard to the student’s *level of training*?” However, in recommending the use of the term “medical student” over terms such as “student physician” or “physician in training,” both the authors of the article and the accompanying editorial jump to the conclusion the patients’ understanding of *level of training* is equal to their overall understanding of the medical training process. Personally, I cannot count the times that I introduced myself as a medical student and received the response, “Oh, that’s nice—so you want to be a nurse when you grow up!” Before discarding the other terms, it would be interesting to study how patients interpret each one, in regard to both level of training and type of training—especially when the name tag is physically attached to someone who doesn’t quite fit the picture of the dashing, young, white, male future physician.—**CHRISTINA NICOLAIDIS, MD**, University of Washington, Seattle.

REFERENCE

1. Silver-Isenstadt A, Ubel P. Medical student name tags: identification or obfuscation? *J Gen Intern Med*. 1997;12:669–71.

In reply:—We agree with Dr. Nicolaidis that patients often do not understand the complexities of medical education. In our experience, patients frequently think that medical students will end training not as physicians, but as nurses, pharmacists, etc. Clearly, patients bring a number of stereotypes to their understanding of the medical profession.

Dr. Nicolaidis understands us to assume that “patients’ understanding of *level of training* is equal to their overall understanding of the medical training process.” This is not the case; we do, however, think that understanding level of training is critical. It is important that

patients not be misled about what a medical student can provide them regarding their care. Our study demonstrated that many labels in common use suggest to patients a relatively high level of training. Patients will most likely make many assumptions on seeing the word “physician” or “doctor” on a name tag, whether or not it is modified by “student.” Those words suggest a heightened level of responsibility not applicable to medical students. Therefore, for the sake of honesty, we recommend the use of the term “medical student,” a label patients clearly understand to denote comparatively minimal medical experience. Patients deserve the opportunity to provide their informed consent to the educational interaction.

Further studies exploring the details of patients’ assumptions about medical training would be valuable and may reveal a term conveying level of both training and career track. Ultimately, we should aim to educate patients so that they can be informed, willing participants in the medical education process.—**ARI SILVER-ISENSTADT, MD**, University of Maryland, Baltimore, and **PETER A. UBEL, MD**, University of Pennsylvania, Philadelphia and Philadelphia VAMC.

Disclosing Medical Mistakes

To the Editor:—Dr. Wu and colleagues are to be congratulated for their courage in bringing attention to a difficult ethical problem.¹ The issue is so thorny and important that I believe it deserves wide discussion: the issue of disclosure of suboptimal professional practice.

A retired physician and a reflective elder, I have thought of things I could have done better in my own practice. Some of these had to do with my response to patients, but the worst were technical errors or blunders. I had to wonder if I was a less competent or more dangerous surgeon than my colleagues. I don’t think I was; in fact, I know that every other surgeon whose practice I was intimately familiar with also made one or more mistakes in judgment. The unfortunate thing about this is that physicians have no forum for admitting and discussing these misadventures.

When I went to medical school, there was a great deal of emphasis, both deliberate and unconscious, upon the need for perfection. It was mandatory to understand and remember things correctly, and make the correct judgment, as the wrong dose of digitalis or the withholding of a necessary operation could be lethal. The implication, of course, was that one could be perfect. No one admitted that each of us ultimately would make terrible mistakes, and we were given no clue about how to handle these ca-

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tastrophes. Secrecy and guilt are the only responses available to many young doctors, other than the intellectually dishonest maneuver of transferring all responsibility to the patient's disease. In addition, the present climate of malpractice litigation makes it difficult to discuss one's own suboptimal behavior openly, and certainly discourages direct disclosure to the injured patient.

I was extremely fortunate to practice within two informal partnerships in which the partners had an unusual degree of mutual respect and trust. We were able to talk openly, inquiringly, and helpfully about instances of questionable decision making or technical performance. Even with this favorable environment, however, I have a few professional matters that remain secret and surrounded by guilt.

In my judgment, it would be very helpful if there were an established mechanism to help physicians acknowledge and deal with their own humanness, and the inevitable inconsistencies, errors, and episodes of irrationality that go with that condition. The debriefing protocols that have been so useful to traumatized firefighters and emergency medical workers come to mind; perhaps some compromise between these closed-door sessions and the confession booth could be devised. If physicians could share their misadventures in such a setting, they might be helped to digest or metabolize the experience, and move beyond the initial self-defensive impulse, which I presume is universal.

When doctors become patients, they seek physicians who are competent, who pay attention to detail, who are scrupulously honest and, if possible, compassionate as well. The doctor-become-patient has a corresponding obligation to be honest and careful in communicating the history, symptoms, and degree of compliance with suggested therapy. Absent any of these elements, the relationship between healer and sufferer is lessened, and becomes potentially harmful. The doctor-patient relationship at its best is the reason most of us became doctors, and is close to the heart of what being human is all about.

If a burdened physician, in some sort of nonthreatening setting, could be helped to refocus on these basic facts, he or she might be empowered to explain to his or her patient the unsuccessful as well as the successful parts of treatment rendered.

Physicians and patients must recognize their dependence on each other, and the special need for trust and honesty in their relationship. In the long run, denial is not a successful way of dealing with human imperfection and error.—**C. PHILIP LAPE, MD**, Brunswick, Me.

REFERENCE

1. Wu AW, Cavanaugh TA, McPhee SJ, Lo B, Micco GP. To tell the truth: ethical and practical issues in disclosing medical mistakes to patients. *J Gen Intern Med*. 1997;12:770-5.