

Editorial

I Need You to be Me: Talking with Our Patients, Their Families, and Their Doctors

Curt Tribble^{1,*}

¹Division of Cardiac Surgery, University of Virginia, Charlottesville, VA 22901, USA

*Correspondence: ctribble@virginia.edu (Curt Tribble)

Submitted: 2 June 2023 Revised: 23 June 2023 Accepted: 26 June 2023 Published: 31 August 2023

Introduction

As surgeons, both in training and in practice, there will be many crucial, and sometimes difficult, conversations that we must have with our patients, their families, and their other doctors. Like many trainees, I did not receive much, if any, instruction or counseling in this realm, either explicitly or by example, when I was a resident [1].

“An academic surgeon has only about 20 July’s in them.”

—Malcolm Perry, MD. 1929–2009

Malcolm Perry, an accomplished Vascular Surgeon and Surgical Educator, was fond of describing the annual academic cycle of having new residents start into their training as being challenging, at best. He was correct. In the annual orientations I have had with new residents over the past four decades of my own career as a surgical educator, with a new set of residents starting each July, I have started these sessions with a simple assertion, which is “I will need you to be me at times”. Obviously, I am conveying to these newly minted residents that they will have to represent me, our team, and our institution. And, one of the biggest challenges for these new residents is, inevitably, talking with patients, families, and referring doctors.

“These skills do not come naturally.”

—Emily Rivet, MD [2]

It is apparent that skills in this realm do not come naturally, as Emily Rivet, a surgical resident at the time, emphasized. I vividly recall a time when I was beginning my own residency in Thoracic and Cardiovascular Surgery residency. On that particular day, a baby whom I and one of my senior mentors planned to operate on, in order to divide a patent ductus arteriosus, died on induction of the general anesthesia, before we had actually made an incision. Despite having one of our very best anesthesiology teams with us that day, we were unable to resuscitate the child. The pediatric cardiology fellow, who happened to be a close friend of mine, and I were sent to speak to the child’s parents. It was one of the saddest days ever, for us all.

My colleague and I took the baby, wrapped in a clean blanket, to the consultation room to talk with the parents, who were barely more than children themselves. The four of us were devastated, each in our own way. Every time we

thought we might be able to, collectively, catch our breaths, something else would come up. For instance, the parents, who had expected to stay in the hospital room with their child that night, realized that they now had nowhere to stay and no transportation to make it back to their home in the mountains of western Virginia, which was a four- or five-hour drive from the hospital. These challenges intensified when we realized that a snow storm was just beginning, as we could all see from the window of the consultation room.

After gathering assistance from social workers for these distraught young parents, my friend and I excused ourselves and returned to the nearby intensive care unit, where our faculty mentors awaited. However, their response wasn’t particularly helpful. They, somewhat callously inquired about the possibility that we might consider changing our career paths, perhaps towards some realm in which we could avoid such emotionally complex situations. Presumably, they believed their comments would help toughen us up. Unfortunately, their banter had the opposite effect; it didn’t provide any solace.

That day I decided, in order to survive, endure, and even thrive in the high pressure realm of thoracic and cardiovascular surgery, I would need to learn to deal with these sad and difficult situations. Upon further reflection, I also decided that I would not allow myself to deal with these tragic situations by not caring or by ignoring the pain of all involved. I promised myself that I would do my best not to send my residents to talk to families by themselves, if at all possible, upon finishing my training.

In the nearly four decades since that day, with very few exceptions, I have kept that promise. Furthermore, I have devoted considerable time and effort to reflecting upon and educating others on the art of navigating such difficult conversations. My situation was not unique: very few students and residents are taught much of anything about how best to deal with these kinds of challenging discussions. It is vital that our proteges learn the skills necessary to navigate them. As the old saying goes: everything matters and nothing is neutral. And this adage is certainly true of challenging conversations that we must all have, from time to time, with our patients and their families.

Indeed, few if any, of these conversations come naturally to any of us. It is obvious that, on occasion, your proteges will have to step into your shoes, and they will

represent you and your team to patients, families, and collaborating physicians. Despite the length of time that our trainees spend under our guidance, it often seems that we turn around and they're gone. They depart before we have trained them in some of the most crucial patient skills.

Therefore, I will impart at least some of the wisdom I have acquired regarding these pivotal conversations in the many years since my residency. I would like my students and residents to integrate these insights into their own interactions with patients and families moving forward. To facilitate this, I will group these thoughts and suggestions based on the types of conversations that commonly occur in the typical course of clinical care, with emphasis on a typical thoracic and cardiovascular surgery practice.

Consultations: What's the Next Logical Step?

When a referring physician asks you for a consultation on a patient, you should realize that they are asking you, and your team for an opinion on what treatment or treatments might be available to that patient. You should approach the patient and the patient's family saying explicitly that you have been asked by that patient's doctors for an opinion on what the optimal treatment for their condition might be, which may include operative and non-operative options. When you meet the patient, make sure that you have thoroughly reviewed the information and studies relevant to that patient's condition at the time. Make it clear to the patient that you, your team, and the patient's other physicians will eventually make a recommendation for whatever you, collectively, believe is the 'next logical step'. This may include more studies or alternative therapies and will incorporate input from all of the clinicians involved. Be thorough in gathering information about the patient, consider the thoughts of others, and be careful in how you present your recommendations to the patient and the patient's family. We'll cover some of the nuances of these various kinds of discussions in the subsequent sections.

Clinic Discussions: Code Switching

"The difference between the right word and the almost right word is the difference between lightning and a lightning bug."

—Mark Twain [3]

Obviously, some of the most important discussions you will have with patients and their families will occur in your clinic, in the preoperative period, in follow-up after an operation, or in longer term follow-up, such as when you are following an aneurysm that has not enlarged to a size that would mandate an intervention [4]. In my own practice, which has included patients from the college town in which I have practiced most of my career and from the sur-

rounding region of Appalachia, I have cared for people with a wide array of different backgrounds. Thus, some of my patients were, literally, among the most well to do people in the world while others were bear hunters living 'back in the mountains'. I got to know and enjoyed them all. In fact, I was invited to the homes of folks at each end of that spectrum, with one of the wealthiest families thanking me in public for saving their patriarch's life (an exaggeration) and with one of the bear hunters presenting me with a bear skin (which I have kept in my home to this day).

One of my favorite medical students told me one day that he, and his classmates, had noticed that I spoke to these various kinds of patients in different ways, often using what my proteges perceived to be a variety of accents. That observation surprised me at the time, as I was unaware that I was modifying my 'accent' or syntax in ways that, upon reflection, I suppose I was doing instinctively, to put these various patients and their families at ease. I later realized that these adaptations in speaking style have come to be called 'code switching', a term that supposedly describes an effort, conscious or not, to adjust language, syntax, or grammatical structure to 'fit in with a dominant culture' [5]. I, of course, was not trying to fit into a dominant culture but was rather, trying to put each of my patients, and their families, at ease. Upon reflection, I will suggest that anything that any of us can do to connect with our patients and to try to put them at ease is well worth doing. After all, there is truth in the old saying that patients won't let you care for them unless they think you care about them. And, trying to 'speak their language' is one of the ways we can strive to connect with each and every one of them. These connections are good for all concerned [6].

Declining to Offer an Operation: You Can't Unoperate

"It is easy to make some people worse, and it can be hard to make them better."

—Walter Merrill, MD

On occasion, you and your colleagues may conclude that an operation is not the 'next logical step' that should be taken for a particular patient. Always take care to convey that you are not necessarily saying that an operation will not be offered. Rather it signifies that you and your colleagues are open to gathering more information or considering an alternative treatment before undertaking an operation. After all, there is truth to the old saying: "You can't unoperate".

Preoperative Discussions: It's Just Another Tuesday

"I could decide who I could trust with my life in about three minutes."

—J.P., Special Forces Officer in The Vietnam War

Once a decision to offer a patient an operation has been made, it is important to ensure that both the patient and their family understand what that operation will entail, including the expected benefits and the potential complications. Once a course of treatment has been agreed upon, you will want to do your best to convey to the patient and their family your confidence in the recommendation and your optimism that the odds are in favor of a good outcome. You will have to ‘read the crowd’ to consider how you convey that message. An example of that sort of presentation, that recognizes their understandable anxiety and your confidence in the plan, might be to say something like “I know that you are, naturally, anxious about this operation next week, but I will say, with hope that it will be of help to you, that the day of your operation will be, for me and my team, “just another Tuesday”. Still, you must convey that you cannot guarantee any specific outcome. You can, however, guarantee that you and your team will be caring, honest, communicative, and collaborative. In summary, the best preparation for the occasionally difficult postoperative conversations will be careful attention to your preoperative conversations [4].

Consent: What We Can Promise and What We Can’t

The final part of the preop conversation is the obtaining of consent for the proposed procedure. While the old phrase ‘first, do no harm’, is part of the basic lexicon of physicians, by definition, performing an invasive procedure involves doing at least some harm, with the expectation of improving the well-being of the patient in the long run. We have written more extensively about the consent process in the past [7].

“Medicine is a science of uncertainty and an art of probability.”

—Sir William Osler [8]

At some point in the consent process, while ‘reading your audience’, there are some reasonable things that one might say including:

- Some people will have this or that happen, but most do not.

- Mother Nature and The Good Lord sometimes impose their own outcomes.

- Just because Plan A isn’t an option, or doesn’t work out the way we had hoped, we will move on to Plan B or C.

- We are quite good at dealing with curve balls.

- Bad outcomes do happen, despite all of our attempts to avoid them.

- Here’s what we can promise, and here’s what we cannot promise...

- Whatever does come next, we won’t abandon you.

“Sometimes people don’t understand the promises they’re making when they make them.”

—John Green, *The Fault in Our Stars* [9]

And, there are some promises you should avoid making, such as:

- It’ll be fine (as that line is disingenuous, at best).

- You have nothing to worry about (as that is obviously untrue).

Who Will Speak for You? The Designated Survivor

In conjunction with obtaining consent, you must sort out who your patient wants making decisions for them if they are unable to do that for themselves. Since some patients may find that this request ominous, at least at first, I have found it helpful to describe how the Vice President of the United States will always be present in The White House if the President is undergoing a procedure that requires sedation or anesthesia. Sorting this issue out is all the more crucial if the patient is single, a widow, or a widower. I have been surprised, at times, by who patients choose for this role, often designating a younger member of their family than I might have expected. I have encountered this lack of clarity on who will be the designated decision maker often enough that I eventually created my own form that the patient and I could fill out together. This document would then become an official part of the patient chart, typically attached to the consent form or uploaded to the Electronic Medical Record.

Dealing with an Urgent Transfer: A Tight Timeline

“No successful therapy for mortal illness can be employed without risk.”

—Bud Frazier, MD, 2010

For those practicing in a tertiary care referral center, it is not uncommon to encounter an urgent or emergent transfer of a patient from another institution, such as an outlying hospital’s emergency room. The expectation in these cases is that an emergent operation will be performed as soon as feasible. You must get the contact information for the patient’s family somehow, as you might not have access to those details if the patient arrives—let’s say, by helicopter—prior to the family’s arrival. You will never regret asking the referring physician to make sure that the family understands the dire nature of the patient’s condition before the transfer takes place. Make sure that physician advises the family to travel safely to your hospital. After all, the last thing such a family needs is to find themselves involved in an accident that may arise from their sense of urgency. We must do our best to ensure that family doesn’t simultaneously end up with more than one member in dire straits!

Communication During Operations: The Parlor Game

“The single biggest problem in communication is the illusion that it has taken place.”

—George Bernard Shaw [10]

While some thoughtful surgeons believe that communicating with the family during an ongoing operation is a good idea, I have never felt that doing so was optimal. I prepare the family ahead of time not to expect these kinds of updates and explain my reasons for this approach. This is because there will almost never be any accurate news to convey until the operation is complete. I tell them that these operations are quite long. While I understand the inevitable anxiety that is part of waiting for an operation on a loved one to conclude, there will almost never be any ‘real news’ to convey. That is, we will not know how the patient tolerated the operation until it is actually over. At that point I will personally find them and tell them what was done and how we thought the operation had gone. I have found that nearly all families understand the reasons for this approach.

The Postop Meeting with the Family: You Must Sit Down

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

—Maya Angelou [11]

First and foremost, as the attending surgeon, it is crucial to personally meet with the patient’s family after completing an operation, and you should, whenever possible, avoid sending a surrogate to deliver the information. This conversation may well be the single most important one that you will have with that family. And, you should meet with them in private, if at all possible. There should always be a designated waiting room or area for the family members of patients undergoing surgery to stay during the procedure. To manage this room effectively, it is ideal to assign a host or hostess responsible for attending to the needs of the family members. When you are ready to talk to the family of your patient, you should call that designated person and ask that the family be moved to a quiet place to wait for your arrival. If things have gone well, it is reasonable for that person to convey the news to the family, as they are being ensconced in the privacy of the consultation room. I believe that it is best to wait until the patient has been moved to the recovery area (usually, in cardiac surgical cases, an intensive care unit) before talking to the family. While waiting for this additional time may make the operation seem a bit longer to the waiting family, you will run less risk of a change in status arising between the time your team started closing up and the time you find yourself talking to the family, a time when our patients are inherently unstable.

Before entering the consultation room, you should silence your phone (or beeper) or, perhaps, hand it off to someone else. You want the family to feel that they have your undivided attention during these meetings. Once you are in the consultation room to meet with the family, I believe that it is best to sit down so that you can avoid standing up and looking down on those to whom you are speaking. You may even have to ask someone in the group to stand for a bit. (After all, they will have been sitting down for hours during the operation.) You should try to identify who seems to be the ‘family member in charge’, which will often be the oldest woman in the room. (Despite some impressions to the contrary, we live in a matriarchal society.) Try to prioritize sitting beside either that person or your patient’s spouse, even if you need to ask someone else to move. You should speak directly to that person and speak loudly enough for others to hear what you are saying [12].

I also fervently believe that your resident should accompany you to these meetings. There are several reasons for this, including that of a demonstration on how these conversations should be conducted, as well ‘validating’ your resident as a colleague who will have a substantial role in the postoperative care of the patient. Even if you do most of the talking, strive to involve your resident in the conversation. For instance, you can ask the resident when he or she thinks the patient is likely to be extubated. After all, your resident is likely to be around the patient, and the family, more than you will be in the coming day or days, and you want the family to consider your resident to be an integral part of the ‘team leadership’. To enhance this concept, I have found it useful to introduce my trainee as ‘my associate’ (which is true), while avoiding ‘labeling’ them as a resident, which might inappropriately undermine their credibility with the family to a degree.

The questions that family members ask may sometimes seem trivial or uninformed, but, a good way to start your response is by saying something like “Now, that is a great question!”. These family gatherings will often include an ‘out of town’er who, frequently, will try to impress their relatives by asking what they perceive to be a challenging question. Your response could start with something like “I am very glad that you are here and that you have asked that question!”. You can chuckle to yourself as that person will, more often than not, puff out their chest, as they want their relatives to know how lucky they are to have such a savvy relative in the mix that day. I have found that a visitor of this sort will usually be long gone by the next day.

Try to convey a feeling that you are not in a hurry in these meetings. While the family may not see all that much of you later in the patient’s hospital stay, given that you may be rounding at all hours of the day and night, they will generally remember your patience with them and your willingness to answer their questions during these postop meetings.

It’s important to ‘under promise and over deliver’ during the early postoperative conversations. For instance,

you can say that you think the patient will be extubated by the next morning, even if you are expecting the extubation sooner than that. Another example of preparing the family for a ‘bump in the road’ is to say something akin to “The patient’s blood was fully thinned during the operation, and, we have drainage tubes that drain the thinned blood away from the heart while the normal clotting mechanisms recover. There are times we need to ‘wash out’ this clotted blood”. You will never regret having set the stage for such a ‘wash out’ of the patient’s chest, should that be necessary. A way to normalize this sort of thing is to say something like “it’s all in a day’s work for us”.

During the first postop meetings, make sure the family has heard about the three main issues that will be focused on in the first 24 hours after the operation. Those issues include bleeding, arrhythmias, and strokes. I like to point out that these are the main reasons that the patient will be in an intensive care unit, with one-on-one nursing and with capable physicians always nearby. And, I like to note that while these issues are, in general, not easy to predict accurately, especially in the early postoperative period, they are generally quite manageable.

Occasionally, despite your best efforts, you will need to manage a ‘hostile audience’. I once had a patient whose operation, in the mind of one particular family member (the patient’s son), had taken longer than expected. When I entered the consultation room, this strapping young man jumped up and pushed me against the wall, asking, stridently, “What have you done with my father?!”. My first instinct was to react physically in some way, but I quickly thought better of that and looked past him, searching for the oldest woman in the room. When I spotted her, I said “I have never been greeted like that, and I am going to leave right now. I will be back in exactly five minutes, and, when I return, I want this young man to be sitting down and saying nothing”. I looked at my watch, turned, and left. When I returned, five minutes later, by the clock, he was sitting right next to the tiny, wiry older woman, who I presumed, correctly as it turned out, was his grandmother. She had his knee clenched in a white knuckled grip. He didn’t say another word, while she said “we’re sorry for that rude and uncalled for greeting. Now, have a seat and tell us what you want us to know”. I am happy to report that, in the ensuing decades, I’ve never had to deal with another situation quite like that again!

Delivering Bad News is Hard

“Sometimes we need not say or do anything other than to be present and momentarily silent, for our patients, their families, and ourselves.”

—Ian Barbash, MD [13]

There will be times when you must convey news of an unfortunate turn of events. You should allow the patient or family to ‘brace themselves’, perhaps by saying, up front, “I

have some bad news”. You should not be overly concerned about future litigation, since a verbal conversation is rarely admissible in court. You should convey your sadness for them, as doing so is not an admission that you did something wrong. And, you can say things like “I know this turn of events is frustrating, terrible, and sad”. You should never seem to be in a hurry at times like these [1].

Opposites Day

Sometimes it is valuable to hear of ways NOT to do or say something. Here are some quotations from a spoof published in The Onion that illustrate this point [14]:

- I’m sorry but there was almost nothing else we could have done.
- If it’s any consolation to you, we did practically everything we could for him.
- Hopefully, in time, you will find some solace in the fact that we gave it a good solid effort. We definitely did the majority of the things we could have done at the end there.
- Even if we had saved him, he was pretty old to begin with, so he probably would have died of something else before too much longer, whether we wore ourselves out operating on him or not.

The Challenge of Phone Conversations with Families

We will all be faced, on occasion, with the unenviable task of conveying unexpected news to family members over the phone. While you should do your best to convey challenging or unexpected news in person, there are times when that is just not feasible. In these situations, you should ensure that you know who you are speaking with and ask if there are others present who can listen in, one way or another. Furthermore, you should consider how much news ‘to break’ to someone if they are alone. One way that I have managed a call of this sort, if the recipient is alone, is to suggest that they ask someone, a relative or even a trusted neighbor, to come to be with the person you are calling. You can offer to call back at a specified time. One admonition that I have learned to convey is to tell the recipient of the call not to jump in their car to drive to the hospital right away, since that person will, inevitably, be a distracted driver. Another strategy for dealing with these challenging situations by phone is to say that “things have taken a turn for the worse and we wanted you to know that, but we need you to stay by the phone for now, and we will call back in a bit with an update”. If you say that you will do that, you must follow through somehow, even if you need to have someone else make the follow-up call for you if, for instance, you have had to perform an urgent procedure of some sort.

A special case of calls of this sort is when the news you need to deliver is unexpected, such as when the patient

has suffered some kind of trauma or a medical disaster, like an aortic dissection. You may want to ‘break the news’ to the recipient of such a call gradually, and you will want them to try to gather ‘a support group’, which might consist of relatives, neighbors, or friends. Again, it is important to help such a person understand that their speeding to the hospital, especially if the distance to be traveled is considerable, is both unnecessary and potentially risky. I have had patients who were flown to my hospital for trauma or an aortic emergency and who arrived in extremis or even dead. I have learned that it often makes sense to convey to a family of such a patient that things “look dire” and that we and our team are continuing to do all that we can, while asking the person you have contacted to stay by the phone for news, rather than making a reckless dash to the hospital and potentially being out of touch while driving.

Timely Communication with Referring Doctors is Essential

During my residency, the faculty surgeons had us call the doctors who had referred the patient to our service after the operations had been completed. Initially, I accepted that practice as routine. Over time I noticed the referring physicians often seemed to think it was odd that the attending surgeon did not personally make these calls. I made a decision that when I became the attending surgeon, I would take the initiative to make those calls myself. I was often told by these doctors that this courtesy was very much appreciated. I also made it my practice to call these docs when there was bad news to convey, as well. Some of these physicians pointed out to me, they often lived and worked in communities where they encountered the families or the neighbors of their patients in grocery stores, gas stations, at PTA, Scout meetings, or church. It is expected that their family doctors would know the outcomes of patients they had referred to us, regardless of the nature of those outcomes.

As a practical matter, I discovered these physicians were often occupied with patients or families when I called. Recognizing this, I began asking the receptionist if the doctor I was calling was available. If they were occupied, I would leave a brief message for them with the news of the day, offering the opportunity to call me back later if they had questions, though it was rare for them to do so. Over the years I have taken the opportunity to ask if this approach of leaving a message worked for them. Almost without exception, they assured me that it did. Naturally, if the operation did not go as planned, I would make every effort to reconnect with the physician, understanding their need for a comprehensive explanation directly from me regarding the patient’s progress. This requirement for communication with the referring doctor extends to the patient’s entire hospital course, particularly when there are notable complexities involved.

End of Life Discussions: Supervising the Sunset

“It is a compassionate God or a compassionate nature, as one chooses, which provides an escape mechanism from our corruptible bodies when they become uninhabitable. Physicians should strive to understand when an escape mechanism is preferable.”

—Jim Jones and Laurence McCullough, 2011 [15]

Inevitably, there will be times when a patient is getting to the point of being ‘beyond further medical intervention’. A reasonable way of thinking, and talking, about these situations is to say something like “as long as we believe we are prolonging living, we will carry on. But, if we realize that we are prolonging dying, we will shift our focus to providing comfort care”.

These conversations, though never easy, are more straightforward if the possibility of this outcome has been conveyed to the family earlier. We have written more extensively about these situations in another treatise [16].

Condolence Letters to Families: Best When Handwritten

“i carry your heart with me. i carry it in my heart.”

—e. e. cummings [17]

In our discipline of Thoracic and Cardiovascular Surgery, we will inevitably have patients who do not survive their operations or hospitalizations. I had learned that some of my older colleagues wrote letters of condolence to the families of patients who had died ‘on their watch’. This is another approach I would incorporate into my clinical practice, sending similar notes to the families. As I noted in a prior essay, I eventually learned that the venerated clinicians I was emulating always sent hand-written notes to the bereaved families [18]. Once I learned of that practice, I made a personal commitment to do the same.

An important aspect of these notes was an offer to be available to those families for any questions that they might have on their minds at a later time. I was amazed at how often someone in such a family would take me up on those offers. A very memorable example of this sort of ‘delayed follow-up’ involved the sister of a young man who had suffered an aortic injury in a terrible automobile accident and who died despite our best efforts. This young woman set up a meeting with me and the residents who had helped me with her brother’s care. The meeting took place on the one-year anniversary of her brother’s death. At the conclusion of that meeting the patient’s sister told us how much it meant to her that we had been willing to meet with her, noting that she had gained a measure of closure regarding the care of her brother [19].

“Kindness is like snow. It beautifies everything it covers.”

—Kahlil Gibran [20]

It is worth highlighting that many families, who seek legal counsel after the death of a family member, do so because they feel a sense of incomplete understanding regarding the events and information surrounding the patient’s demise. This is especially true in the midst of the chaotic circumstances that often accompany such a loss. I have been commended by these lawyers for my practice of sending letters of condolence, which serve as a genuine expression of my concern for the families and my willingness to discuss any aspect of the care their loved one received from us, rather than as an attempt to evade litigation. In my experience, these exchanges have consistently resulted in positive outcomes for all parties involved. To be clear, I am not suggesting that this type of communication should be relegated to a trainee. Instead, I believe it is valuable for your trainees to be aware of this practice and to learn from the experiences shared when, and if, they arise.

Involving Residents in the Care of Your Patients: You Gotta be Me

“Unless we find a way to revive the relationship between resident and patient, and, thus, the dedication and purpose that fuel imagination, the quality will not be what it was, let alone what we want it to be.”

—Atul Gawande, MD [21]

I have always told my residents that “you gotta be me”, i.e., there will be situations where they will represent me and our teams to a family without me or another attending surgeon. These situations often arise when you are unable to respond to a call or fulfill a request for more information due to being out of town or otherwise unavailable. If you have taught your proteges well, more often than not, they will successfully represent you and your team. In fact, I, frequently receive feedback from my residents who are many years out of their training that modeling and teaching them about these difficult conversations has remained among their most valuable and cherished memories of their time in our training program.

Summary

“I wish every physician could understand - without going through the unimaginable - that our success in this profession isn’t defined by achieving external validation metrics but rather by our ability to care for and about our patients.”

—Ethan Sanford, MD [22]

There are many occasions when crucial and challenging conversations with patients or their families must be conducted. A lot of thought and planning should be

given to how, where, and with whom these conversations should be conducted. And, it is very important to involve your trainees in these conversations as often as possible, as demonstrating your approach will be as valuable to them as any of the technical tips and tricks that you will pass along to them during their time in training with you. After all, each of them will soon be gone, hopefully representing you and your program out in their own world. If you have done your job well, they will, indeed, have become you.

Author Contributions

This manuscript was completed by CT, alone.

Ethics Approval and Consent to Participate

Not applicable.

Acknowledgment

Not applicable.

Funding

This research received no external funding.

Conflict of Interest

The author declares no conflict of interest. CT serves as associate editor of this journal. CT declares that he had no involvement in the processing of this article and has no access to information regarding its processing.

References

- [1] Hudnall JA, Kopecky KE. The Empathy Project: A Skills-Development Game: Innovations in Empathy Development. *Journal of Pain and Symptom Management*. 2020; 60: 164–169.e3.
- [2] Bagley J. Delivering Difficult Patient Conversations Is A Skill To Be Learned, Practiced. *Bulletin of The American College of Surgeons*. 2023; 8–13.
- [3] Mark Twain Quotes. Available at: <https://www.goodreads.com/quotes/4957-the-difference-between-the-almost-right-word-and-the-right> (Accessed: 10 May 2023).
- [4] Tribble C. The Well-Tempered Clinic: The Clinical and Educational Importance of Cardiovascular Surgical Clinics (With a nod to Johann Sebastian Bach). *The Heart Surgery Forum*. 2020; 23: E712–E717.
- [5] Beeharilal D. Code-Switching and Identity: Embracing an Intentional Approach. *Forbes*. 2020. Available at: <https://betterup.com/blog/code-switching> (Accessed: 10 May 2023).
- [6] Tribble C. All the Light We May Fail to See: Learning from

- Talking to Strangers. The Heart Surgery Forum. 2021; 24: E690–E699.
- [7] Tribble C, Julliard W. First, We Do Harm: Obtaining Informed Consent for Surgical Procedures. The Heart Surgery Forum. 2019; 22: E423–E428.
- [8] Sir William Osler. Available at: https://www.brainyquote.com/quotes/william_osler_159326#:~:text=William%20Osler%20Q uotes&text=Medicine%20is%20a%20science%20of%20uncer tainty%20and%20an%20art%20of%20probability (Accessed: 10 May 2023).
- [9] Green J. The Fault in our Stars. Available at: <https://www.theguardian.com/childrens-books-site/2015/ jan/13/the-greatest-john-green-quotes-ever#:~:text=The%20F ault%20in%20Our%20Stars,That's%20what%20love%20is> (Accessed: 10 May 2023).
- [10] George Bernard Shaw. Available at: https://www.brainyquote.com/quotes/george_bernard_shaw_385438 (Accessed: 10 May 2023).
- [11] Maya Angelou. Available at: <https://www.goodreads.com/quot es/5934-i-ve-learned-that-people-will-forget-what-you-said-p eople> (Accessed: 10 May 2023).
- [12] Tribble C. Grandmother Rules: Crucial Conversations with Patients and Families. The Heart Surgery Forum. 2017; 20: E002–E006.
- [13] Barbash IJ. Silent Space. The Journal of the American Medical Association. 2018; 320: 1105–1106.
- [14] The Onion. I'm Sorry, But There Was Almost Nothing Else We Could Have Done. 2009. Available at: <https://www.theonion.com/im-sorry-but-there-was-almos t-nothing-else-we-could-ha-1819584643> (Accessed: 10 May 2023).
- [15] Jones JW, McCullough LB. Patient-originated futility insight: ethical right or ethical plight? Journal of Vascular Surgery. 2011; 54: 237–239.
- [16] Tribble C. Knockin' on Heaven's Door. Heart Surgery Forum. 2017; 29: E111–E115.
- [17] Cummings EE. 1952. I carry your heart with me. Available at: <https://www.poetryfoundation.org/poetrymagazine/poems/ 49493/i-carry-your-heart-with-me-i-carry-it-in> (Accessed: 10 May 2023).
- [18] Tribble Md C. On Becoming a Doctor of Humane Letters. The Heart Surgery Forum. 2016; 19: E150–E152.
- [19] Senior J. What Bobby McIlvaine Left Behind. The Atlantic, September Issue. 2021. Available at: <https://www.theatlantic.com/magazine/archive/2021/09/tw enty-years-gone-911-bobby-mcilvaine/619490/> (Accessed: 10 May 2023).
- [20] Kahlil Gibran, in Quotespedia. Available at: <https://www.quotespedia.org/authors/k/kahlil-gibran/kindness-i s-like-snow-it-beautifies-everything-it-covers-kahlil-gibran/> (Accessed: 10 May 2023).
- [21] Gawande AA. Creating the educated surgeon in the 21st century. American Journal of Surgery. 2001; 181: 551–556.
- [22] Sanford E. Losing Ceci. The Journal of the American Medical Association. 2023; 329: 1451–1452.