Supplemental Digital Appendix 1

REFLECT (Reflection Evaluation for Learners' Enhanced Competencies Tool) Rubric Applied to a Reflective Narrative from a Second-Year Student in the Doctoring Course at Warren Alpert Medical School of Brown University, Providence, Rhode Island

Reflective Narrative

Writing Prompt

Delivering Bad News: *Consider a circumstance where you or someone you know was on the receiving end of bad news. Reflect on both the intellectual and emotional responses. If applicable, do others remember the event similarly or differently? What did the person delivering the bad news do well? What could he or she have improved? How do you think this experience will inform your career in medicine?*

Student Narrative

> *Your CT scan came back. We don't know if it's cancerous yet, but we found a mass in your bladder and we're going to need to refer you to urology for some more testing.*

I've often heard it said that no one likes to hear his or her own voice. When we see ourselves on TV, or hear our voices recorded on an answering machine, it can almost feel like we don't recognize the person talking. I'm no stranger to this phenomenon, having had to grapple with the sound of my own voice as I recorded tracks for my college a cappella group. I had never experienced those same feelings of disconnect in real time though, never felt as though the person talking was somehow not me, until last Tuesday.

My patient was a [omitted for privacy protection] who presented to the ED [emergency department] with three episodes of painless hematuria interrupted by two-week breaks with no symptoms. He had well-controlled hypertension and BPH [benign prostatic hyperplasia] (medicated with enalapril and tamsulosin), but other than that, he had no relevant family, social, or past medical history, and his physical exam was completely negative. All in all, he was the picture of healthy aging. Except for his cranberry-colored urine.

Proving the value of the "Do you have any concerns about what this might be?" question, my patient came up with the differential for me. "The way I figure it, it's gotta be an infection, a stone, or cancer," he nonchalantly replied, validating the sick feeling I had lurking in the pit of my stomach as I desperately tried to come up with a differential that didn't have malignancy as the number one possibility. I pushed my suspicions out of my mind, assured him that there were a number of infections, stones, clotting disorders, and vascular malformations that could cause painless bleeding, asked him to sit tight while we ran some tests, and quickly retreated. Inevitably, though, his intuition was correct. CT revealed a 2 x 2 x 2 cm mass in the anterior wall of his bladder, with an ominous note from the radiologist explaining that it was

"concerning for malignancy." My patient would now need to meet with a urologist, get a biopsy, undergo rounds of testing, surgery, and potentially radiation therapy. In short, his life was about to change drastically. And I was the one feeling sick.

I've seen bad cases before. I've watched patients wither and die of HIV in Africa, seen anguished relatives learn that their loved one didn't make it, and observed doctors working with families to figure out whether palliative care is the best option. And none of it had affected me to the extent that I now felt contemplating this man's diagnosis. Part of it was because he seemed so healthy, so likeably alive. I had never truly contemplated the cruel randomness of cancer before. But part of my disconcertment came from the fact that I was actually playing a role now; I had helped figure out that he might have cancer, and I was going to be one of the faces he associated with his diagnosis.

Ultimately, my mentor thought it would be best for me to say the first few lines, then to refer all further discussion to him. The logic of it made total sense—I had been the one interacting with the patient, I had a good rapport with him, and given my patient's suspicions about his ailment, I probably wouldn't find a better-equipped patient to learn how to break news to. Everything seemed reasonable. And still I felt sick.

> *Your CT scan came back. We don't know if it's cancerous yet, but we found a mass in your bladder and we're going to need to refer you to urology for some more testing.*

The words came spilling out, sounding alien and cruel. I was instantly ashamed that I had hidden behind cold, clinical language. I couldn't even bring myself to say "I'm sorry," couldn't acknowledge the exquisite humanity of the situation, couldn't do anything but spit out my words and hope the patient didn't blame me. I heard what I was saying and didn't recognize the person speaking the words. It was like listening to a recording in real time.

And that was the problem. I had gotten so caught up in how everything *should* go, what words I *should* say, how the patient *should* feel, that I made the experience about me. I had thought I was reacting to how painful this would be for my patient, but I was making the whole experience about me. My awkwardness. My trepidation. My guilt at bearing bad news.

The patient didn't catch any of this. He reacted to the news as well as could be expected, his smile-lines furrowing as he contemplated the implication. He listened carefully to his follow-up instructions, and signed his discharge paperwork. Firmly shaking my hand he wished me well and thanked me for taking such good care of him.

I hadn't, of course. I had treated him coolly, clinically, and ultimately distantly. I had introduced my hang ups into the relationship in an unacceptable way. But next time I give a patient a "bad" diagnosis, next time they thank me for taking care of them, I'll make sure the experience is theirs, not mine.

REFLECT Rubric Application Process

Writing Spectrum: The overall style is reflective, critically reflective. Based on a detailed and compelling description, the author is weaving self-awareness and noticing during the encounter with reflection in and on action, following the surprise of experiencing in real-time his delivery of bad news as different from what he hoped for.

The REFLECT rubric requires "*Exploration and critique of assumptions, values, beliefs, and/or biases, and the consequences of action (present and future)"* for Critical Reflection level. In the present note, the author explores and critiques assumptions ("I had thought I was reacting to how painful this would be for my patient, but…"), beliefs ("I had never truly contemplated the cruel randomness of cancer before"), and actions (the consequences seem to be internal for the author only). The learning is transformative: "Next time I give a patient a 'bad' diagnosis, next time they thank me for taking care of them, I'll make sure the experience is theirs, not mine."

The evidence for transformative learning is in the commitment to applying the understanding in the future, painfully gleaned through the reported experience and reflection. **Overall Level: Critical Reflection. Axis II: Transformative Learning.**

Individual Criteria

Presence: Evidence of full and deep presence is prevalent in the text with multiple instances of writing from "I", such as: "I heard what I was saying and didn't recognize the person speaking the words. It was like listening to a recording in real-time." This is an unusually compelling example of mindful presence. **Level: Critical Reflection.**

Description of conflict or disorienting dilemma: The disorienting dilemma is clearly and eloquently formulated: "There's a first time for everything, and that includes bearing bad news," and, "he wished me well and thanked me for taking such good care of him. I hadn't, of course. I had treated him coolly, clinically, and ultimately distantly." There is a conflict between the hope for an empathic, compassionate delivery of bad news and the awareness that in reality this wasn't happening. However, the author doesn't detect an influence of his lack of compassion on the patient, nor feedback for such a problem from the mentor, which may indicate a self-appraisal that is too harsh. Overall, "*multiple perspectives, exploring alternative explanations, and challenging assumptions*" as the REFLECT requires for a level of Critical Reflection is not fully realized. **Level: Reflection.**

Attending to emotions: Emotions are reported in multiple instances, are recognized ("the sick feeling I had lurking in the pit of my stomach") and ("I was instantly ashamed"), explored ("I had never experienced those same feelings of disconnect in real time"), attended to ("I had thought I was reacting to how painful this would be for my patient, but I was making the whole experience about me. My awkwardness. My trepidation. My guilt at bearing bad news."), and an emotional insight is gained ("I had treated him coolly, clinically, and ultimately distantly. I

had introduced my hang ups into the relationship in an unacceptable way.") **Level: Critical Reflection.**

Analysis and meaning making: The author analyses his perceived suboptimal performance through both emotional (see "Attending to emotions") and cognitive lenses, e.g., "I had gotten so caught up in how everything *should* go, what words I *should* say, how the patient *should* feel, that I made the experience about me." The meaning-making is evident in relating: "never felt as though the person talking was somehow not me, until last Tuesday," with the transformative learning mentioned in the Writing Spectrum paragraph above. "Next time, minding my emotions, making the patient's the focus of my concern, I will strive to be compassionate and empathic" is implied and appears to be expressed in the last sentence of the narrative in an oblique, toned-down manner. **Level: Critical Reflection.**