Looking into the chasm

A student reflects on the disconnect between the classroom and the exam room.

BY DOMINIC DECKER

The gap between the second and third years of medical school felt like a chasm. On one side were the preclinical years, filled with innumerable lectures and labs about health and disease. On the other were the clinical years, when learning takes place in patient-care settings. Ideally, the first half of medical school should segue nicely into the second. In reality, the transition is difficult, as students confront the complexity of managing patients who exist outside the confines of clinical vignettes. As I near the end of my third year, I’ve been reflecting on this critical time in my education with a greater awareness of what transpired as my passive, hypothetical learning became very active and real.

Last April, as my second-year courses in hematology and gastroenterology ended, I anticipated the next milestone in my training: Step 1 of the United States Medical Licensing Exam (USMLE). The six weeks during which I prepared for this exam were a hypercondensed version of the first two years of medical school. Studying involved reviewing material and doing practice questions for 10 hours a day, six days a week. I made extensive charts, drew elaborate diagrams and committed obscure details to memory in the event they would help me answer a single challenging question. Rote memorization became my full-time job.

During this intensive study period, I sealed myself off in the back bedroom of my apartment, the extra space I had made mandatory on my list of requirements when I had been apartment hunting, precisely because of the USMLE. An hour-long break in the middle of the day to exercise was my respite from attempts to categorize important pathogens and, thus, determine their clinical significance and treatment. In conversations with my boyfriend at the dinner table, I allowed my mind to momentarily drift from the causes of micro-, normo- and macrocytic anemia. I visited my parents occasionally, rarely saw friends and did not speak to fellow classmates because I felt commiserating during this time was unproductive.

My mantra during exam preparation was: “This will make you a good doctor.” In trying to convince myself that I was studying for the benefit of my future patients, I sought to imbue Step 1 with meaning. That may have worked because I truly believed it, or it may have been that I was too busy memorizing to question the value of the test.

On the morning of May 29, I went into the testing center feeling simultaneously prepared and unprepared. I was fingerprinted, photographed and placed at a workstation to answer hundreds of questions over eight hours. For me, the reward at the end of the exam was not being done with it, nor was it getting my score. It was the conclusion of the preclinical years and the beginning of my practical, hands-on training. It was my gateway to patient care.

I had one weekend off between Step 1 and the first day of my third-year rotations. And it was during a single moment...
in one of those first rotations that I realized how little the test had prepared me for the art of doctoring.

That moment brought me face-to-face with a man my age who had returned to the clinic for the results of a testicular ultrasound. He had noticed a painful mass on one of his testes several weeks earlier but had been reluctant to have it evaluated. Intense discomfort finally brought him in. After reviewing his chart, I knew that the growth was likely cancerous and that treatment would mean removing the affected testicle. I walked into the room, trailing behind the doctor and resident who gently delivered the news. Then I was left alone with the patient to arrange for follow-up.

Sitting next to the exam table upon which my patient sat, I looked into his eyes as he began to cry. Over and over, he questioned what had caused his cancer and whether his testicle would have to be removed. He was concerned about his fertility, a problem that rarely if ever crosses the mind of an otherwise healthy man in his 20s. I knew then that being a good doctor meant not telling my patient about the cells that made up his cancer or about the tumor markers used to identify those cells. I knew that he was trapped in a room in which the word “cancer” had just been released like a noxious gas. I knew it was suffocating him. And in all of this, I knew that my role was simply to listen and be present.

Suddenly, I saw things clearly. So much of my studying was meant to elicit an automatic response when I heard a phrase like “muddy brown casts” or “Reed-Sternberg cells.” It had conditioned me to think that even the most complicated question had a single best answer. As I thought inside the box, I ignored the nuances inherent in the patient as a person.

In health care today, we are rejecting a one-size-fits-all approach in favor of advances in genomics and individualized medicine, or what President Barack Obama called “precision medicine” in his State of the Union address. So why are tests written as if one 45-year-old woman with hypertension is the same as another 45-year-old woman with the same diagnosis?

Before I entered medical school, I studied narrative medicine at Columbia University. This discipline recognizes that the central act of connection between doctor and patient is the story that is exchanged and constructed by both parties. It trains health care workers—not just physicians, but nurses, social workers, chaplains and others—to skillfully listen to, interpret and act on the illness narrative. We students honed and refined those skills as we analyzed how messages were presented in a variety of media, from literature to music to film. Learning how to critically think about art and to appreciate the diverse reactions it inspires has helped me better understand complexity, concordance and contradiction in my patients.

My training in narrative medicine, elsewhere referred to as medical humanities, has completed my medical education, allowing me to step outside of an overly formulaic approach to patient care and instead try to gather information that is meaningful both to myself and the patient. Such training is the exception rather than the norm in medical schools and residency programs in the United States, but it is growing.

As I started my third year, I remarked to several friends and family members that it feels like I’m not in the same program anymore. In many ways, I’m not. My classes are held at the bedside or in staff workrooms. My instructors are doctors, nurses, technicians and, especially, patients. My answers to questions are not A, B, C or D. Incorporating the humanities into medical training starting in the preclinical years would bring the art and science of medicine into balance. It would also help students bridge the divide between the patient on the exam paper and the one on the exam table.

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