Becoming a doctor

By Brett Chevalier

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As my graduation from medical school approaches, I find myself frequently reflecting on my four years as a student at DMS. Firsthand experience interacting with patients has been the most powerful learning tool for me. For most of my classmates, our first encounter with patients occurred in the "On Doctoring" course, which we take in years one and two. We each shadowed a preceptor, a community physician, and learned to apply basic interviewing and physical examination skills to clinical experiences.

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I remember being very nervous when I had to knock on an exam-room door and then interview a patient with a chief symptom of "cough." I had little idea what I was doing. I tried to recall the mnemonic to pin down the "HPI" (history of the present illness): CLEARAST—character, location, exacerbation, alleviation, radiation, associated symptoms, severity, and time frame. But I remembered few of the appropriate questions. The remainder of the interview was even more disorganized as I struggled to gather as much information, pertinent or not, as I could. The physical exam was equally perplexing. Having listened to few lung and heart sounds at that point, I had only a vague notion of what was normal or abnormal. My classmates have similar stories about their initial patient encounters.

Empathetic: Fast-forward to today, more than three years later. A teenage patient presents with a cough. Now I can perform a structured and streamlined, yet thorough and empathetic, medical interview, as well as a focused physical exam, ruling out serious causes of illness. I counsel this teenager about quitting smoking in language that is meaningful to her. I leave the exam room to present the case to my preceptor. My preceptor's physical exam and diagnosis confirm my findings: an upper respiratory infection (a common cold).

I have come far. But I still have far to go before I truly master the skills of interviewing patients, conducting physical exams, interpreting lab test results, or medically managing complex cases. Ironically, the further I advance into my medical education, the more I realize how much there is yet to master.

Although one of our main goals has been to learn the arcane language of medicine and the complexity of disease processes, most of us entered the field of medicine for humanistic reasons: the privilege of forming relationships with patients during crucial times in their lives and of being able to provide them with care. Unfortunately, other pressures on physicians—lack of time; reimbursement problems; and difficulties talking to patients and families about complications, the possibility of dying, or death—threaten to displace this humanistic side of medicine.

But a mentor told me recently, "Brett, you have the skills to learn what you need to about diseases and medical management during your residency. Medical school is about learning how to be a doctor." This seemingly unintuitive statement reminded me that the countless hours I have spent studying my notes and refining my diagnostic skills would be all for naught if I fail to treat my patients with the same compassion with which I would treat a member of my own family.

The following story explains this tenet. Mrs. C is a 40-year-old Chinese woman with breast cancer who needed exploratory surgery to investigate an ovarian mass. I met her this fall during an away rotation in gynecologic oncology. Complications occurred during the surgery; significant hemorrhaging and damage to blood vessels in her leg meant amputation was a possibility.

Alone: Mrs. C and her husband, neither of whom understood much English, were confused and devastated. Mrs. C was alone in her hospital room, unable to walk without assistance. Her husband couldn't be with her during the day because he had to work to avoid losing the health insurance that would pay for chemotherapy for her breast cancer, as well as for the treatment she needed following her surgery.

As the medical student on her care team, I gathered her vital signs and performed a physical exam each morning. I realized, however, that she needed my presence and my support more. Each morning for the rest of her several-week hospital stay, I sat on the edge of her bed, holding her hand and letting her cry in front of me. Despite the language barrier between us, she seemed to feel comforted. I did little more than what any family member would do. Yet I think I did more for her this way than I ever could have by contributing to her medical management.

Compassion: Although one of the unspoken prerequisites for medical school is being kind-hearted and compassionate, applying this compassion and empathy is not always second nature. At the beginning of medical school, I did not have the experience to recognize that a small act of compassion such as sitting at the bedside can mean the most to a patient. I now understand that compassion is the most important component of being a doctor.

In a few months, I will have the honor of being able to put "M.D." after my name. But the closer I come to that exciting and formidable event—graduation day—the more critical I am of my skills in my quest to be as prepared as possible for residency. My learning "curve" during residency will probably resemble a vertical line.

Yet Mrs. C called me a few weeks ago to thank me and tell me how she was doing. I guess she thinks I'm ready to be a doctor. ■

"Student Notebook" shares word of the activities or opinions of students and trainees. Chevalier is the 2005-06 president of the DMS Student Government. A member of the Class of '06, she plans to go on to a residency in obstetrics and gynecology.