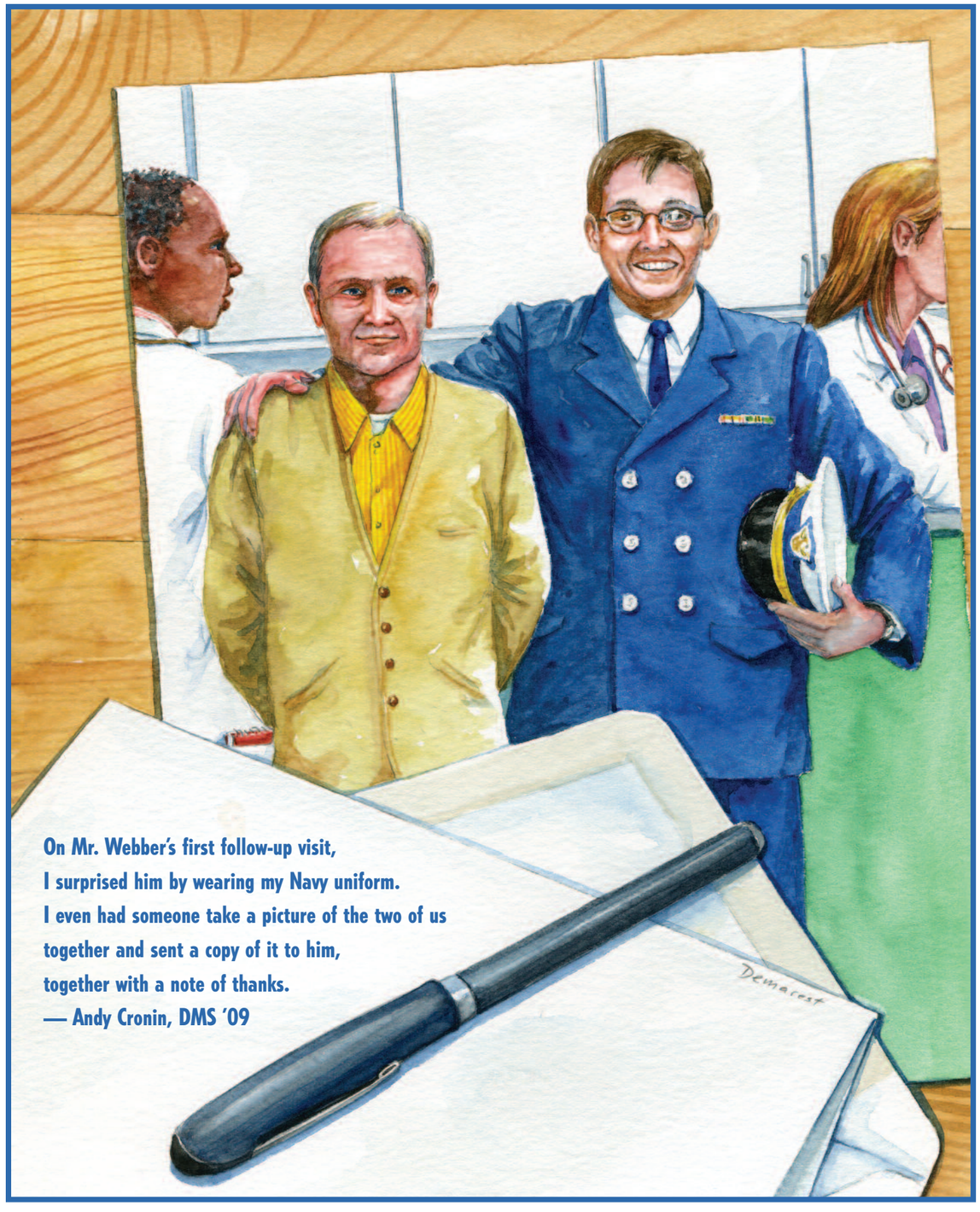


PATIENT TEACHERS

Illustrations by Chris Demarest

Turning medical students into doctors is a job that calls for scientific acumen, medical expertise, and lots of patience. And it calls for patients, too. Many students say that the most powerful lessons they learn—especially those about the importance of the human touch—are insights that they glean from patients. Here are several such sagas.

A uniform finding

By W. Andrew Cronin

Andy Cronin, who earned his undergraduate degree in chemistry from the U.S. Naval Academy, will graduate in June from Dartmouth's M.D.-M.B.A. program. After a transitional internship in 2009-10 at Balboa Naval Hospital in San Diego, he will serve for three years as an undersea medical officer; he then plans to enter a residency in anesthesiology.

I was a 21-year-old rising senior at the U.S. Naval Academy when an encounter with a 20-year-old Marine changed my career path forever. He had been shot in the neck in Afghanistan but, thanks to the commitment of his fellow soldiers, had been extricated from the battlefield under heavy fire, stabilized by medics in the combat zone, and evacuated to a military hospital, where his left carotid artery was repaired and his life saved. I worked with him for two weeks during his rehabilitation after his return to the U.S. I was amazed that this man, younger than I, who had nearly sacrificed everything for the country he believes in, was determined to return to full health so he could rejoin his unit. I hadn't yet learned about the stages of wound healing that his body was undergoing, hadn't yet mastered the neurologic tests that were being used to monitor the stroke he had suffered due to the incident. But I was able to play a meaningful role in his care simply by taking the time to listen to someone who was half a country away from his family and half a world away from his friends who were still fighting. I went home in the evening after working with him convinced that there was no greater profession than medicine.

When I first came to medical school, my excitement and passion were at an all-time high as I met a community of like-minded classmates, all in pursuit of the same goal: to become doctors. At first, my passion to provide care to patients drove me to learn as much of the science of medicine as possible. However, I gradually began to separate out the art from the science of medicine. Fortunately, a few elements of first year kept my spirit nourished—most notably the On Doctoring course, which gave us contact with patients and an opportunity to discuss the human side of medicine in weekly small-group sessions, as well as the community service activities we were encouraged to engage in.

But slowly I began to assign the caring, compassionate parts of me to the Thursday afternoon On Doctoring sessions, while my disciplined, driven aspects took charge the rest of the week. The more I separated science from the rest of my persona, the

These five narratives were written by Dartmouth medical students upon their induction into the Gold Humanism Honor Society. A national organization with chapters at 72 of the nation's 129 medical schools, the Gold Society recognizes students for their compassion and dedication to service. For last year's Dartmouth induction ceremony, the society's newest members were asked to describe an especially meaningful encounter during their medical education. Five of the narratives prepared for that occasion have been adapted for publication here. The names of all the patients mentioned, as well as key identifying details about their cases, have been changed in order to preserve their confidentiality.

more studying became a chore—a forced march to get from first year to second, then from second year to third—instead of a way to provide better care to patients.

I didn't realize how separated the art and the science had become in my mind until I met Mr. Webber on my internal medicine rotation in October of my third year. Mr. Webber was a retired Navy veteran who had been admitted for the third time to the VA Medical Center for recurrent ascites—an accumulation of fluid in the abdominal cavity. He had a reputation for having been a bit gruff, even mean, with previous medical students. I was determined to get beyond his "difficult" personality and find the cause of his ascites. But luckily for me, he was determined to remind me of something I knew but had forgotten since being in medical school.

"Mr. Webber, can you describe to me what has happened since your previous admission?" I asked.

His response came in the form of another question: "What is that symbol on the bottom of your tie?"

"It's the Naval Academy crest." I replied quickly and immediately asked another question: "How soon after you went home did your ascites recur?"

Ignoring my question, he asked another: "Are you a Navy man, Mr. Cronin, because I served 21 years in the Navy, in both the Atlantic and Pacific fleets."

"I am in the Navy. Thank you for your service. Are you in any pain?" I kept my responses to his questions short, hoping to deliver the message that I was in the room to talk about his health, not about the Navy.

"The Navy is where I met my beautiful wife, sitting there," he said. He was just as persistent at ignoring my questions as I was at deflecting his.

After a few more rounds of the two of us talking past each other, his persistence won out. I stopped resisting and spent some time hearing about the ships that he had served on and the deployments that he had completed. What I learned was that Mr. Webber was not mean but very funny, that he was not gruff but scared. He was worried about the cause of his recurrent ascites, about the strain his condition was putting on his wife, about whether it might shorten his life.

I spent the next few days investigating all the causes and possible treatments for ascites. But even more important, I spent time at the end of each day getting to know Mr. Webber better. We traded sea stories. I shared with him everything I was learning about his condition and why it was difficult to pin down a specific cause. He and his wife told me about how they had met and emphasized the importance of their relationship in each of their lives. As I invested time in him, he invested time in me. He shared insights from a patient's perspective about what makes a good doctor. He even requested that I perform his paracentesis—a procedure to draw out the built-up fluid through a thin, hollow needle—knowing full well that I had never performed one before. I thanked Mr. Webber for the experience, and he told me it was an honor to be a part of my education.

Though we continued to run lab tests and to consult with experts in gastroenterology, we were unable to determine the underlying cause of his ascites. We discharged him with a plan for frequent follow-up visits, hoping that closer management of his condition would avoid any more long hospitalizations. The day he left for home, one of his last comments to me was that he'd love to have served in the Navy with me and to have seen me in my uniform.

Although I had been unable to identify a cause or cure for his problem, this latter request was one I could fulfill. On Mr. Webber's first follow-up visit, I surprised him by wearing my dress Navy uniform. I even had someone take a picture of the two of us together. I had one print developed for myself, to serve as a reminder of the lesson I'd learned from Mr. Webber, and I sent another copy to him, together with a note of thanks. I thanked him for reminding me why I had gone into medicine. I thanked him for reminding me that the reason for all my science classes was so I could better serve my patients, and that in that context studying was not a chore but a resource I would draw on again and again. And, finally, I thanked him for reminding me that even though I may not always have a cure, I can always care for the patient.

I spent the next few days investigating all the causes and possible treatments for ascites. But even more important, I spent time at the end of each day getting to know Mr. Webber better. We traded sea stories. I shared with him everything I was learning about his condition. He and his wife told me how they had met. As I invested time in him, he invested time in me.
— Andy Cronin '09

Doing battle

By Andrea Pearson, M.D.

Annie Pearson graduated from Dartmouth Medical School in 2008 and is currently a first-year resident in internal medicine at the University of Massachusetts's Saint Vincent Hospital. She did her undergraduate work at Holy Cross, majoring in psychology.

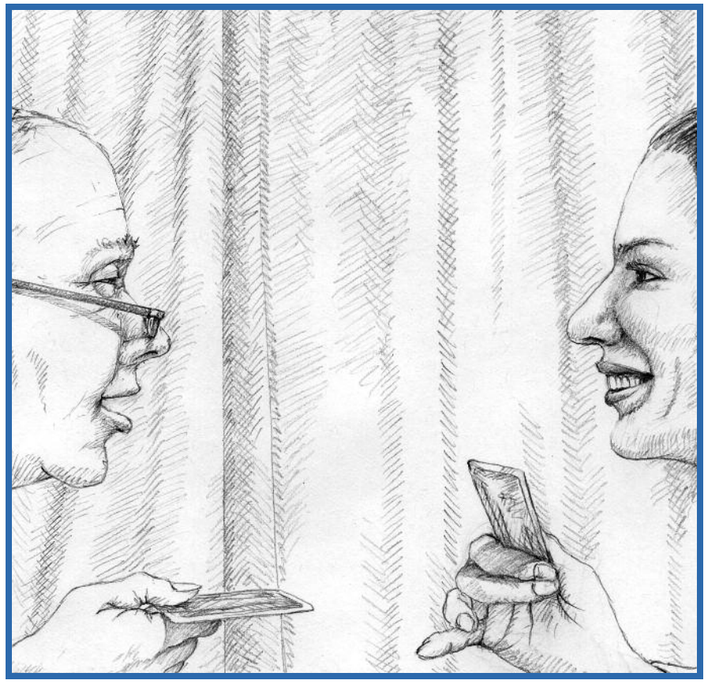
The very first patient I met upon starting my third-year clinical rotations was my most memorable one, for many reasons.

I'd drawn surgery as my first rotation. The night before the eight-week stint started, my mind tried desperately to prepare as I double-, triple-, and quadruple-checked my bag to ensure that I was carrying everything I would need: Lunch, check. *Surgery Rapid Review*, check. Extra hair elastics and barrettes, check. Stethoscope, check.

Next to my bag lay my carefully organized white coat—my name badge and beeper clipped to its lapels and its pockets filled with blank note cards, information cards, pens, a mini flashlight, and breath mints. It probably weighed 30 pounds, but I felt "loaded and ready for battle." Finally, it was time to review the notes I had taken regarding the next morning's first patient.

He was an elderly male and had a history of smoking, though he'd quit some time before; he was having surgery because a nodule had been identified on his left lung. I flipped through my *Rapid Review* book in the section labeled "Lung Lesions," so I'd be ready for the inevitable questions that the medical student on the team gets asked. Then I scanned the internet for a description of a thoracotomy so that I would know what was happening in the operating room.

At last, I resigned myself to the fact that I would have to learn as I went along, and I went to bed.



Early the next morning, the senior resident on my team took me in to meet Mr. DeFelice before he was rolled into the OR. He was a friendly man and was accompanied by his three daughters, who were equally pleasant.

As my senior resident explained the procedure to Mr. DeFelice and his family, I stood at her side, watching this interaction between doctor and patient. And then we were gone—off to check quickly on two other patients before we changed into scrubs and entered the OR. In the surgery locker room, I took one last quick glance at my *Rapid Review*, tossed it in my locker, and then prayed that I'd remember how to put on my gown and gloves.

Once the procedure was under way, though the OR was a fairly large room, I remember feeling that no matter where I stood I was in the way. The operation itself was amazing; I remember watching the surgeon in awe of his ability to navigate the human body with such ease. I followed the nodule he'd excised from Mr. DeFelice down to the pathology lab and then returned to give the surgeon the news that it was indeed cancerous. But we'd also taken tissue samples from several of his lymph nodes, and fortunately it appeared that the cancer was still localized and that we had removed all of it.

After spending a few hours in the recovery room, Mr. DeFelice was brought up to the ICU. Then, once he was deemed stable, he was transferred to a regular inpatient room. There, I began making daily visits to check on his progress. His was initially a typical course for a patient who has had a thoracotomy—he had a tube emerging from his chest and was in a lot of pain. The main things I was supposed to focus on were air leaks from his chest tube and his level of pain.

Unfortunately, neither problem resolved as quickly as we'd hoped. His air leak continued for 24 days, and his pain proved very difficult to manage. During the first couple of days, despite the severity of his pain, Mr. DeFelice maintained the friendly nature that I recalled from our first meeting. I enjoyed our visits every morning, even though they were brief. We talked about where he was from, and I discovered that he had been the main contractor of the elementary school that I had attended. He told me about his family, and I could tell how close they were and how devoted he was to them by the way that he spoke. His daughters visited him daily, at different times, and I would often see them in the hallway as they came and went.

I found those early morning visits, as well as rounds with my whole team, increasingly informative. But I always had to run off to that day's operations, and I'd leave feeling that my work was not complete. My presentations were getting more efficient, my plans more accurate, my notes more complete. But my first patient was still in the hospital and did not seem to be making any progress.

One of Mr. DeFelice's biggest problems was vivid

He told me about playing cards with his daughters and granddaughters at the lake in the summer. I asked him if he'd like to play some cards before dinner, and he smiled. I grabbed a deck of playing cards in the volunteer services office, and we played a couple of games of War.
— Annie Pearson '08

I always spoke to Mike while I performed the exam, letting him know what I was about to do next. While I was not sure if he could hear me, speaking out loud to this teenage boy seemed like the right thing to do. Maybe a part of me was hoping that one day he'd speak to me in return. — Jen Talmadge '09

room, we talked about various things. He told me about his daughters and his grandchildren and about their favorite times—playing cards with them at the lake in the summer. I asked him if he'd like to play some cards before dinner, and he smiled. I walked down to the volunteer services office and grabbed a deck of playing cards. We played a couple of games of War, and I left the cards in his room for the following evening.

Things didn't completely change overnight, but after three evenings of cards, conversation, and a lot of encouragement, he was able to go home.

About two weeks later, I received a letter in the mail from his daughters, thanking me for taking such good care of their dad. They told me what a difference it had made for him when I went back to see him at the end of the day.

I felt like I'd gone to battle and had won the war.

Reminder of resilience

By Jennifer Murray Talmadge

Jen Talmadge, currently a fourth-year medical student at Dartmouth, also did her undergraduate work at Dartmouth, majoring in biochemistry. She hopes to enter a residency in radiology this summer.

hallucinations that were a side effect of his pain medication. Though we changed his medication once, we were more concerned with his ongoing air leak and so asked a consultant from the Department of Psychiatry to handle this psychiatric symptom. But it continued to persist. I hated to walk into the poor man's room each morning and see his terrified face; he was exhausted as a result of sleepless nights and was becoming increasingly apprehensive about being in the hospital. His daughters had never seen their father like this. He had always been a pillar of strength, the rock of their family. Now he was afraid. And his nurses were clearly exasperated.

I decided to dive into the case and asked for one day out of the OR to spend some time looking into it. I called the psychiatric consultant and discussed the case with him. I told him about a journal article I had found which laid out a medication protocol to treat pain and deal with hallucinations in postoperative patients. He supported my thoughts, and I ran the protocol by my team. We implemented the new plan that evening. As I explained the change to Mr. DeFelice and his daughters, it was clear they were desperately hoping for some improvement.

I made my own rounds that evening, checking in on all my patients. When I got to Mr. DeFelice's

As medical students, we get a lot of practice with change. We are an intimate part of people's lives, often when they are at their most vulnerable, for a moment or a day or a week. Then we move on to another rotation, another hospital. Most of the time, that is. A few patients stay with us forever. And occasionally, we are lucky enough to get to see one of them again, when we least expect it. That's what happened with Mike Powell.

It was a chilly February morning, and I was on my way to take a practice test for my medical boards. I stopped at the hospital café to pick up my usual hazelnut coffee, and as I fished for change with my left hand while trying not to spill the steaming cup in my right hand, I spotted a familiar couple across the room. We made eye contact, and although I had not seen them in six months I placed them immediately: Mike Powell's parents, Diane and Rob.

Let me back up six months to the previous August, when I first met Mike, a 14-year-old boy who had been an unrestrained passenger in a motor vehicle accident. It was my first day as a subintern in the pediatric intensive care unit (PICU). Mike arrived there in critical condition, with extensive brain damage, elevated intracranial pressure, bruised lungs, a torn spleen, and over 20 broken bones—including several unstable vertebral fractures. For his first few days on the unit, Mike was in and out of the operating room repeatedly for life-saving interventions.

Every day during my PICU rotation, I examined Mike. His body was swollen and broken and still. I pinched his fingers, rubbed his breastbone, lifted his eyelids, and shined light onto his pupils. There was no response. Rods, lines, and tubes connected to various monitors emerged from his warm, perspiring body. I always spoke to him while I performed the exam, letting him know what I was about to do next. While I was not sure if he could hear me, or honestly if he would even live another day, speaking out loud to this teenage boy seemed like the right thing to do. Maybe a part of me was hoping that one day he'd say "Good morning" in return. I never heard Mike speak or even withdraw from pain, but he did make progress in the PICU. Each day I checked his ventilator settings, monitored his intracranial pressure, kept track of the modifications in his complex medication regimen. I looked for sores, contractures, infections, and clots. I perused lab tests, imaging results, and assorted consultants' opinions and helped communicate our team's plan to his family.

A couple of weeks into his hospitalization, planted as a stinging reminder that time moves on even when life seems to stand still, Mike turned 15. Members of his extended family and numerous friends showed up throughout the day, including the guilt-ridden driver of the wrecked car. We sang an enthusiastic albeit off-key rendition of "Happy Birthday." The usually quiet and spare hospital room buzzed with energy and filled up with balloons, cake, cards, and photographs. I distinctly remember one picture of a mud-covered, invincible teenager, grinning after a soccer game, his arm around his little brother. But through all the commotion, Mike didn't stir or open his eyes.

I often thought about Mike and his family before I fell asleep at night. I kept wishing that I could do more for them.

Four weeks after the accident, a bed at a rehab facility opened up. Mike, though still unresponsive, was deemed stable enough to be transferred. I figured I'd never see him again, especially since I was about to finish my month on the PICU.

I went on to rotations in other specialties and soon found my attention diverted by preparing my residency applications, planning my wedding, and studying for my boards.

But six months after I'd last seen Mike, lying in his PICU bed, here were Diane and Rob smiling in the hospital café. I was thrilled to see them again. Diane had been at the hospital day and night for Mike's entire stay, and Rob had visited daily; I quickly remembered the fragile, human time we had shared. I sat down with them, as though I were catching up with old friends, and listened to the story of Mike's amazing recovery.

Soon after leaving the hospital, Mike had begun opening his eyes, responding to verbal cues, and even speaking—at first mostly cursing at those around him. A few months into his daily, physically demanding rehabilitation, he took his first step with a walker; after a few more months of practice, he'd learned to walk again. By the time I ran into Diane and Rob, he was living at home, walking, talking, using a treadmill, and attending school part-time. As I recalled my last glimpse of his broken and motionless body, it sounded like the closest thing to a miracle I had ever witnessed. Indeed, a local TV station had covered his story under the headline "Miracle Mikey."

Diane and Rob were at the hospital that day because Mike had just been readmitted with a relatively minor upper respiratory tract infection. "He is in room 519," Diane said. "Do you have time to come visit him?"

This time, I entered the pediatric floor as a guest of Mike's parents, not as a member of his care team. I was wearing jeans and a fleece jacket—no white coat, no stethoscope, no reference books weighing down my pockets. Just as I had immediately placed his parents, I also knew Mike right away. The fluid had left his face, his spinal brace was gone, and the ventilator tubes were missing, but I recognized the blue eyes of the young man sitting on the hospital bed, playing a video game. He politely turned off the game when I entered and stood up.

There was my comatose patient, standing in front of me, taller than I, smiling and shaking my hand. "It's nice to meet you," he said. He spoke slowly, but his physical and intellectual capabilities astounded me. "It's great to see you again," I responded. He laughed a lot, and he and his parents teased each other when their stories about his recuperation differed. They showed me the "Miracle Mikey" video and newspaper clippings about his recovery. Mike thanked me for helping to take care of him, but I knew he was the one who had given me a gift.

My face and my heart were smiling for a long time after I left his room that winter day. Mike Powell is a patient I will remember forever. He reentered my life when I least expected it—on a cold Saturday morning when my mind was filled with anxiety about my upcoming board exam—and reminded me of the resilience of the human spirit.

There was my comatose patient, standing in front of me, taller than I, smiling and shaking my hand. "It's nice to meet you," he said. "It's great to see you again," I responded. He laughed a lot, and he and his parents teased each other when their stories about his recuperation differed. They showed me the "Miracle Mikey" video and newspaper clippings about his recovery. — Jen Talmadge '09

I suddenly started sobbing. My attending put her arm around me and just sat there with me while I cried. After a few moments, I pulled myself together and apologized for my behavior, but my attending said, "There's no reason to apologize. You are just having a human day."
— Kandice Nielson '08

In the medical profession, we become familiar with change, death, disease, and uncertainty. At times it can feel overwhelming. But I believe all health-care providers can recall a patient like Mike—someone who reminds us that even in the darkest of times, in one way or another, hope and humanity prevail. These are the patients who inspire us to go to work every day. These are the patients whose courage we hope to emulate. These are the patients we must never forget.

Embracing emotion

By Kandice Nielson, M.D.

Kandice Nielson graduated from DMS in 2008 and is currently a first-year resident in obstetrics and gynecology at the University of Colorado. As an undergraduate, she majored in biology at the University of Utah.

All medical students enter medical school with the hope that they will make a difference in medicine and in the lives of their patients. Sometimes, however, the grueling parts of learning medicine overwhelm us, and we forget our original reasons for becoming doctors and overlook the human side of medicine. My experience on the palliative medicine service taught me many lessons about being a doctor, but the most important one was about retaining my humanism—balancing being human with being a doctor.

That was brought home to me most meaningfully by a patient who had a very aggressive and advanced squamous cell cancer of the head and neck. Mr. Sawyer was a patient I had come to know well on a previous rotation, but now I was seeing him on the ICU as part of the palliative medicine service. We had been asked to meet with Mr. Sawyer and his family during this final stage of his life, to help clarify his goals and to discuss end-of-life care. We supported him and his family in their decision to withdraw life-prolonging treatments and, in the process of our discussions, learned a great deal about Mr. Sawyer and the kind of person he was.

The palliative-care team was fortunate to be present at his death, which was one of the most moving experiences I have ever witnessed. His daughter and sons were gathered around his bed, holding his hand and comforting him in his final moments. Then his children began singing hymns, ending with their father's favorite—"The Lord's Prayer." As they finished the song, he passed away. It was the most peaceful and beautiful death I have ever experienced.

We stayed a few more moments in the room, saying goodbye to the family, then the team's attending physician and I left the ICU. As we were leaving, I suddenly started sobbing uncontrollably—right in front of my attending. I was surprised how much Mr. Sawyer's death had affected me.

My attending looked at me and said, "Why don't we find somewhere to debrief?" We went into a little conference room, and she put her arm around me and just sat there with me while I cried. After a few moments, I was able to pull myself together. I apologized for my behavior, but my attending looked at me and said, "There's no reason to apologize. You are just having a human day." The way she phrased it—"a human day"—really struck me and has stayed with me ever since.

I learned from her that it was all right to cry and to be touched by my patients' experiences. Often medical students and doctors are taught to suppress the emotions that can well up in life-and-death situations, but that leads to physicians becoming jaded and cynical. I learned that day that it was okay to be a doctor and still react like a human being.

This was an important lesson, one that I needed to learn and one that applies to everyone. We are all of us—doctors, nurses, patients, and family members—only human. Health-care providers too often forget the human side of medicine and refer to patients by their diseases. But their diseases aren't what define them—they, just like all of us, are defined by their life stories, their families and friends, their hopes for the future. My own hope is that remembering this experience will make me a better person and a more humanistic doctor.

Part of patients' lives

By Heather Sateia, M.D.

Heather Sateia graduated from DMS in 2008 and is currently a first-year resident in internal medicine at Barnes-Jewish Hospital in St. Louis. Her undergraduate degree is in English, from Princeton.

It was the final two weeks of my medicine subinternship, during my fourth year of medical school, and I was feeling pretty confident about my medical knowledge and clinical skills. Until I met Mr. Miller, that is, and was reminded of how much I still needed to learn and even of a few lessons I had already forgotten.

Mr. Miller was a typical admission to the medicine service: an older man with diabetes, high blood pressure, high cholesterol, and diabetic ulcers that resisted healing. He'd had multiple revascularization surgeries and was facing another bypass operation, on the large arteries of his left leg, in the hope that it would improve his circulation enough to heal a large foot ulcer. But that wasn't his most pressing problem: he'd been admitted this time for treatment of osteomyelitis, a bone infection that is a frequent complication of diabetic foot ulcers.

Medical students on a care team are often asked to "take a history" from patients—interview them about the details of their current and past health status. This both helps students appreciate the progression and interconnectedness of health-care problems and brings another set of eyes and ears to bear on patients' care.

So even though Mr. Miller's history had been taken many times before, my attending had asked me to take it again. I walked into his room, introduced myself to Mr. Miller and his daughter, and began asking them questions. As the conversation progressed, I noticed that Mr. Miller seemed to expect me to remember certain past events in his life and that, while addressing me, he referred to his wife as "your mother." After the interview ended, I walked out of the room with his daughter, who immediately pointed out that her father thought I was one of his daughters. But rather than seeing this as cause for concern about her father's mental status, she considered it a sign of how comfortable he had felt with me—as the reason he had been so willing to open up during our conversation.

After I went home that night, I couldn't stop thinking about Mr. Miller. As I mulled over what had transpired, I began to understand the import of what had happened that day. He had reminded me of the privileged role that physicians play in their patients' lives. To him, my role was virtually indistinguishable from that of a family member. While a myriad of medical conditions could have accounted for his mental lapse, it was nevertheless a potent reminder of my responsibility as a health-care provider: I needed to care for him as if he were my father—indeed, for all of my patients as if they were members of my family.

As I continued to help care for Mr. Miller, I found he had still more to teach me about the humanistic side of medicine. One day we were having a rare slow afternoon on the medicine floor, so my attending, Dr. Edward Merrens, decided to hold a teaching session. Rather than sit in a conference room and discuss in the abstract the intricacies of diabetes management or the new cholesterol guidelines, Dr. Merrens took us to Mr. Miller's bedside. He asked Mr. Miller and his wife if they'd feel comfortable with our discussing some of his physical findings. Mr. Miller immediately sat up straighter, smoothed his hair, fixed his bedsheets, and eagerly replied that he would be happy to help.

The team's other medical student and I took turns identifying abnormal physical exam findings as we looked over Mr. Miller. Dr. Merrens asked us what each finding meant and how it tied in to our patient's overall clinical status. Mrs. Miller would sometimes chime in with a question, and we would translate our findings so that she could understand them. We discussed, for example, why Mr. Miller's left arm had so many broken blood vessels (they were due to sun damage while driving), why his shins were brown (this was because of hemosiderin deposition, or the accumulation of excess iron in his cells), and why he had no hair on his legs (this was from vasculopathy, or damage to the blood vessels—in this case due to diabetes).

Both Mr. Miller and his wife were rapt during our discussion; they had never thought to ask many of these questions but now could identify and understand the various physical manifestations of the diseases that affected him. But what was most remarkable was not the fact that this exchange was taking place among the patient, his family, and the medical team. We could have been discussing a hangnail on his left little finger and it would have had the same effect. Mr. and Mrs. Miller clearly ap-

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— Heather Sateia '08

The Supply Side of Medicine

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with first-year enrollment expected to surpass 5,000 next fall—a 40% increase over just the past five years.

Even Dartmouth Medical School has answered the call to grow. "Our senior class size a few years ago was about 68 to 70 a year, and in a year or two I think it will top out at about 83," says Nierenberg. "Something like 83 is probably what Dartmouth can do to help the country and still have the resources to do a superb job of training students."

Still, all that growth might not result in a significant increase in the actual number of doctors. Those medical-school graduates must go on to train as residents at teaching hospitals before entering practice, and most of the funding for residencies is provided by Medicare. But as part of the 1997 Balanced Budget Act, Medicare funding for this purpose remains capped at 1996 levels—about 80,000 residency slots—and it would take action by Congress to lift that cap. For now, at least, what seems likely to happen is that the growing number of U.S. medical graduates will displace some of the graduates of international medical schools, who currently fill about one-fourth of residency slots.

TDI researcher Elliott Fisher doubts that Congress will lift the cap anytime soon on spending for graduate medical education (GME). Russell Robertson, the chair of the Council on Graduate Medical Education, agrees. COGME has not officially revisited its stance on the physician workforce, but Robertson says at this point he doesn't recommend an increase in GME funding. "I'm increasingly convinced that lifting the GME cap isn't a good idea," he says. "I'm more and more convinced that what we're doing right now is probably going to produce a surplus of physicians."

The AAMC, however, has urged Congress to increase Medicare funding for residencies. That call seems likely to grow louder as medical-school enrollment increases.

Clearly, the debate over the physician workforce is far from settled. Goodman, for one, has no plans to stop asking the questions raised by his experiences two decades ago in Colebrook. The difference is that now, they no longer seem quite so heretical. ■

Worthy of Note

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Corrine Kravitz, a fourth-year medical student, won second prize for her poster presentation at the northeast meeting of the Society of Teachers of Family Medicine. Her poster was titled "Adolescent Motivation as it Relates to Self-Image and Concrete Planning."

Francoise Righini, director of records management and health information at DHMC, was elected to the board of directors of the Northeast Health Care Quality Foundation.

Erratum: A story in the "Vital Signs" section of the Winter 2008 issue of the magazine incorrectly asserted that "snowboarders are more likely to hit the back of their head than the front." In fact, the research led by Dr. Susan Durham showed the opposite—that snowboarders are more likely to hit the front of their head than the back. Our apologies for getting our facts . . . well, backward. ■

Patient Teachers

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preciated being part of the process and interacting with the health-care team. It was an incredible educational experience for me—certainly from a physiological perspective (I did learn a lot about diabetes management that day) but also from a humanistic perspective. Dr. Merrens was able to seamlessly incorporate teaching the two of us students with building a relationship with the patient and his family. It was a technique and an experience that I will not soon forget.

The two weeks I spent caring for Mr. Miller were, in essence, a syllabus in the practice of humanistic medicine. Mr. Miller reminded me from the moment I met him of the incredible role that physicians play in patients' lives and of the responsibility that comes with that role. He also was pivotal in demonstrating how caregivers' interactions with their peers and coworkers are another component in the practice of humanistic medicine and of how seamlessly those relationships can dovetail with direct patient care.

I feel lucky to have seen such a stunning example of how humanistic medicine can be practiced. I hope I spend my career working to remember these lessons and to incorporate them into my own practice. ■