Every year thousands of doctors emerge from med schools, crammed with all there is to know about their patients. EXCEPT, IT SEEMS, HOW TO DEAL WITH THEM AS HUMAN BEINGS

“DR. Z. COMES HIGHLY RECOMMENDED,” Liza said. “They say he’s the best in his field.” This, of course, is a medical cliché. No one ever says, “My surgeon is 23rd in his field, but I’m going with him anyway.” Liza (as I will call her) is a friend with breast cancer facing surgery. She had asked me to go along with her on a consultation with her surgeon, when they would discuss her options. Yes, of course, I said. Since I was doing research for this article on the relationship between doctors and patients, I was also curious to see a top-flight, traditional medical education in action. Liza, who works in broadcasting, is a thin, strong woman with a good laugh. Humour is a big part of who she is and how she copes—even after the death of her husband, from cancer, a little over two years ago. When it turned out she had two kinds of cancer on the go, she sent me an e-mail titled, “One lump or two?” Luckily, she had a good GP, who had sent her for a routine mammogram — an unusually vigilant move, since Liza is only 40. It turned out that she had a small tumour, it was cancer, and it would have to come out. So the appointment was made with Dr. Z., and we waited. In the meantime, I continued to look into the current health of medical education and what we teach our future doctors about the role of the patient.>
THERE’S AN INTERESTING STUDY that measures how long patients get to talk before the doctor interrupts,” says John Kelton, dean of the Faculty of Health Sciences at McMaster University, “and the average time is 23 seconds.” He looked both wistful and optimistic. “If we could even push that to a minute, we’d be getting somewhere.”

McMaster has always kept the patient in the picture since its medical school was launched in 1969. Over 200 medical schools worldwide, including Harvard and the University of Toronto, have since adopted some version of McMaster’s innovative “problem-based learning” curriculum. With this approach, there’s more emphasis on the value of compassion, teamwork and communication. Students spend less time sitting in lecture halls and have earlier contact with patients. PBL (as it is known in the blizzard of acronyms and buzzwords that are the currency of academic medicine) uses small, student-driven tutorials in which students learn from individual cases — from patients, in other words.

“It’s time to take it further,” said Kelton. “We invented the eight-track and everyone said, ‘How wonderful!’ Then PBL became theology. Now we need to move on and invent the iPod.”

So a revamped medical curriculum will be launched at McMaster in the fall of 2005. There will be more emphasis on the “basic concepts that underlie the science of medicine,” just as spelling is coming back in early education, but the focus on the importance of the doctor-patient relationship will remain and deepen. Subjects such as medical ethics and communication skills will be integrated into the program rather than pushed to the margins, as they often were in the past.

One of the faculty members involved in teaching the new curriculum is Cathy Risdon, holder of the David Braley and Nancy Gordon chair in family medicine. “You can’t just have a separate course in ‘how to be a human being.’ Those values have to permeate the whole curriculum.” The goal is to narrow the gap between the art and the science of medicine.

This is easier said than done. Most medical schools pay lip service to the clinical prowess that used to be called “a good bedside manner,” but even the illustrious Canadian physician William Osler, who wrote the world’s first great medical textbook in 1892, warned that this was a difficult skill to teach or master. “It is much harder to acquire the art than the science,” he wrote in 1907, “and the old art cannot possibly be replaced by, but must be absorbed in, the new science.”

“Osler is my hero,” said Kelton. Indeed, Osler is a sainted figure whose countenance floats over many med school corridors. Born in Bond Head, Ontario, he grew up to teach medicine at McGill, Johns Hopkins and Oxford, becoming, in his time, the most famous doctor in the world. He was disciplined, alarmingly vice-free and cultured, devoting exactly an hour each day before bed to reading outside medicine. His century-old ideas about the art of medicine sound more relevant by the day: “We expect too much of the student, and we try to teach him too much,” he wrote in 1903. “Give him good methods and a proper point of view, and all other things will be added, as his experience grows.”

Describing himself as a “pluralist of the most abandoned sort,” Osler was a passionate advocate of patient-centered, hands-on training. “Medicine is learned by the bedside and not in the classroom,” he urged his students. He even wanted his epitaph to read, “He taught medicine in the wards.”

Practising family medicine used to be one way to learn bedside manner on the job, if not in school, but one of the sad facts of health care right now is that the general physician has become an endangered species. Only one in five graduates goes into family medicine. Many students focus early on specialization, and more of them are aiming for the saner hours and higher wages of careers in dermatology and ophthalmology. The broad clinical experience and people skills of the GP now have less prestige than deep, narrow knowledge in one area.

Musing on all this, I looked up the study Kelton had cited. And there I stumbled on a tiny, compelling fact.

In 199 doctor-patient interviews, only 28 per cent of patients got to the end of their concerns before the doctor interrupted. And yet, those who were allowed to finish their story took an average of only six seconds longer. Six seconds, in which the most important medical clues sometimes came to light.

So it’s not really about doctors lacking the time to be compassionate — it’s about whether or not they value that connection.

LIZA AND I SAT in the waiting room of a Toronto hospital clinic. This is never a festive situation, but for Liza it was even more unsettling, because it was the same hospital where her husband Paul had spent more than a year going through chemotherapy, radiation and dawn trips to emergency. They had made many friends among the doctors and nurses who cared for him, but Liza had some lingering bitterness about his treatment. Paul’s early symptoms, which he did his best to ignore, were misdiagnosed by his doctor. By the time his pain sent him to an emergency room and his cancer was detected, it was too late for a cure. His doctors recommended chemo and radiation anyway, as a palliative measure. Liza didn’t agree, but went along with Paul’s wishes. The chemo ride was wretched. It didn’t help. Then he died.

Two years later, she developed pains in her back. “I know it sounds crazy,” she told me one day, “but I keep thinking I have cancer.”

“Well, that’s ridiculous,” I said. “It’s just post-traumatic syndrome talking. Every twinge you get is going to ring the cancer bell.”

Liza wasn’t sure. “I keep thinking this back pain is Paul talking to me, saying, ‘Go to a doctor, check it out.’” How we laughed.

Six months later, we were in a breast clinic, waiting for her name to be called. A nurse led us to a small examining room. Liza donned the famous...
blue hospital gown, with its useless ties in all the wrong places—the first ritual shedding of identity, not to mention dignity, in a medical encounter. Time passed. Our witty repartee wilted. The door opened. In came a bespectacled young man in a white lab coat, carrying a clipboard. Yet again, Liza went over her history for him; why, we weren’t told. Perhaps he was a student. Perhaps he had wandered up from the Tim Hortons in the lobby. He left. Time passed. The door opened, and someone who was clearly The Surgeon entered: tall, clean, pink, good-looking in a bland sort of way. He brought with him a sense of time urgently ticking. Dr. Z. introduced himself, shook our hands and rolled a stool in place.

He went over Liza’s options, which ran the gamut from the conservative—a mastectomy—to a less invasive procedure, with more attendant risks. There was a lot of information to absorb and a complicated decision to make. It was hard for Liza to get even a handhold on this new rockface she was climbing.

We were both very aware of those other women out there, waiting. I thought Dr. Z. was quite patient and thorough for a busy surgeon, but Liza was reacting to other things: how his knee bounced up and down under the table; his cool, opaque manner. If he was aware of Liza’s recent experience with cancer, he didn’t let on. And he seemed to be throwing a lot of information her way without putting the fixed ropes in place that would help her arrive at a decision. Liza was composed and asked a lot of questions about what to expect after surgery.

“Well, you might have not have full range of arm movement for a while,” said Dr. Z. He demonstrated by windmilling one arm.

“I guess that means I won’t be going back to my job at Lester B. Pearson,” said Liza, making the semaphore gestures that airport workers with those orange batons use to guide the planes into place. Dr. Z. looked puzzled. “I don’t really work at the airport,” she said meekly. She kept making little left-field jokes like that, trying to find a point of contact with this frosty fellow who had inherited such power over her body and her life. As he was drawing a breast-circle on his clipboard to show her the incision site, she interrupted.

“But doctor, will I be able to play the piano after the surgery?”

“That’s odd, since I don’t play the piano.” The surgeon looked at her as if she were from Mars.

“It’s a joke,” Liza wanly explained again. Silence. The interview lurched forward, but from that point on, the communication between them dried up. Liza became Patient A, the surgeon Dr. Z. Admittedly, the piano joke was a bit lame, but her demand for an ordinary human response—a laugh, or even a groan—was something he wasn’t comfortable offering.

For Liza, humour is an aspect of compassion. It levels the playing field between doctor and patient and allows people to be more themselves under extraordinary circumstances. Dr. Z’s withdrawal from her playful attempt to engage—his unwillingness to go those extra six seconds—set them off on the wrong foot. This pivotal decision to engage or remain aloof is what author Arthur Frank, professor of sociology at the University of Calgary, might call a moral moment—a situation in which we can choose to give, or withhold, what is really being asked of us. >
Frank is the author of The Wounded Storyteller, a classic in the growing new field of narrative medicine. This approach stresses the importance of treating illness in the context of the patient’s own story. In his eloquent new book, The Renewal of Generosity, Frank explores the relationship between doctor and patient, and the string of rapid-fire ethical decisions that characterize this encounter: how much to say, what hope to extend. And how do we recognize a moral moment? By our uneasy desire to escape it. It’s the moment when a doctor senses that something is being asked of him or her—not just medical expertise but human consolation.

The problem is, classical medical education can subtly endorse the withholding of consolation. This withholding falls under the heading of “professional behaviour” or “respecting patient boundaries,” but in offering consolation, doctor and patient could both respect the boundaries and restore some of the humanity that medical training drains away. There might be healing in this for doctors, as well.

Frank argues that the weakening of the connection between doctors and patients has contributed to demoralization among doctors, too. More of them are leaving medicine. “These physicians know they are doing important work that serves others, but they feel that something crucial to who they are is being destroyed in the process.” Yes, we’re all living longer lives (and seeing more doctors) as a result of advances in technology and skills, but, as Frank writes, “there is no reason why the skilled touch cannot also be generous.”

After Dr. Z. left, Liza got dressed. The clinic nurse poked her head into the room. “Anything I can help you with? Any questions?” Liza talked to her about how soon she could go back to work after the surgery. The nurse talked in useful detail about what to expect and how active she might be. Her manner was direct, light, thoughtful and kind. When Liza said that she really didn’t feel like attending a patient-education workshop—“I’ve put in enough hours in this hospital to last me a lifetime”—the nurse said, “I hear you. That’s OK.” And she did hear her. It wasn’t so much what she said that was reassuring. It was how she listened.

AT McMaster’s Medical School, learning how to listen, how to deliver bad news and just be present in the room are a major part of “professional competency,” a subject students study in their final year.

“We want diligence, intelligence and knowledge, of course,” said Cathy Risdon, “but we also want students with insight into themselves and a will-ingness to be self-aware and self-critical. It can’t just be about stuffing people with information.”

It was, in fact, a posse of doctors fed up with their traditional medical training who developed the patient-centered style of teaching at McMaster.

Geoff Norman, assistant dean of the Program for Educational Research and Development at McMaster, told me the story of how Dr. John Evans and his four rebellious colleagues hatched a new sort of medical school in the mid-’60s.

“Their dreams were very simple. They said, look, we had a crummy time becoming doctors. It was a dehumanizing, degrading experience, and surely it doesn’t have to be. I think a direct quote from one of the ‘founding fathers,’ Bill Walsh, was ‘All we want to do is get our MD and have fun doing it.’”

Traditional medical education was structured around lectures. lab work and learning subjects in isolated clumps: anatomy, physiology, biochemistry, epidemiology. It left the patient out of the picture until the end of a student’s training. Then the graduate was launched, ready or not, into the real world of doctoring. The goal of compassionate care, of addressing human suffering rather than just the disease process, was relegated to other professions further down the power and wage totem poles: midwives, nurses and palliative-care workers. This cure/care dichotomy runs very deep in the medical profession.

Physicians are only beginning to catch up to what palliative-care workers and nurses have always known about pain management and other areas of “patient-centered medicine”—a phrase that ought to be a tautology, but isn’t.

Evans and his colleagues helped put the patient back into the centre of the picture. Students, instead of studying the function of the kidney in the abstract, learn about it in the context of Mr. Walton, for example, a sixty-two-year-old smoker who recently lost his wife and fears going on dialysis. This approach asks students to adapt what they learn to someone with singular emotions and his own eccentric kidney. It makes medicine more personal.

PBL also stresses teamwork, lifelong learning and a focus on how to learn, rather than on how much one knows. “I don’t know, but I’ll look it up” is a familiar phrase in a tutorial. (Of course, this is a frequent challenge from skeptical traditionalists to McMaster students—have they learned enough?)

The “look it up” factor is also part of a larger shift of power in the doctor-patient relationship; we can all Google “kidney disorders” now. Doctors are no longer the gatekeepers of a privileged cache of knowledge. Patients visit their GPs with an inch of print-outs from medical Web sites. Doctors have to be fast on their feet and comfortable working in partnership with these aggressively informed patients. The days when students crammed for four years, graduated, then put their books back on the shelves are over.

Of course, not every student likes or is suited to the PBL approach. Stanley Liu, a resident in radiation oncology in Toronto, preferred the “pseudo-PBL” he experienced as a postgraduate at the University of Toronto. “To me, PBL is like communism,” he said. “Great in theory, but it doesn’t work in practice.”

Geoff Norman, a laid-back guy with a white beard, is refreshingly unpeda-gogical about which sort of program works best. “Bright, creative students can always survive whatever curriculum we throw at them,” he said cheerfully. “The evidence suggests that good teachers are three times more influential than curriculum. We’ve done a lot of testing to see how our grads do. In the licensing exams, McMaster students tend to score about the same as students from other universities: a little lower in surgery, a little higher in psychiatry
and a few other subjects. One study of family-medicine graduates did find that McMaster grads tend to work as long, but they will see fewer patients, with whom they spend more time.”

The undergrad population at McMaster is currently about 70 per cent female; this is a higher ratio than at most universities, but in general the majority of med students is now female. Fifty-six of 128 McMaster grads went into family medicine last year, which is more than the sorry national average of 26 per cent. Right now, Canadian med schools are falling far behind the public demand for doctors: Ontario alone has a shortfall of 2,000 (this despite large numbers wanting to enter the field; last year, 4,150 candidates applied for McMaster’s 138 slots). Small towns in particular are going begging for physicians, but with so many graduates opting for a specialization many residency positions in family medicine remain unfilled.

“HI, MRS. WINSLOW, it’s Adam. I’m here to ask you a few questions. Is that all right with you?”

Adam Spencer, a second-year McMaster student, is visiting one of the patients assigned to him on the internal medicine ward of Hamilton’s Health Sciences Centre. Mrs. Winslow, 88, seems to have suffered some mild seizures, but she has other things going on, too.

Mrs. Winslow is sitting in a chair, her frail body lost inside a dark fleecy robe, her short, straight grey hair held back by a child’s barrette. She looks utterly withdrawn, like a person living at the back of a deep cave. As nurses come and go, her presence in the room is almost negligible. In front of her is a movable food tray holding an array of plastic containers with bent straws. Her dentures are out, and her profile is caved in. Adam introduces me to Mrs. Winslow, and her mild blue eyes take me in. A glimmer of amusement. Writing, about this? What is there to write about?

Adam is 28, a francophone and the eldest of six kids from a family in Dubreuilville, a small town in northern Ontario. He has a master’s in health science research and came to McMaster from a thriving consulting business in Toronto. Now he is headed for an anesthesia residency. His manner is friendly and easygoing. Adam crouches down to be at eye level with Mrs. Winslow. He takes her hand and talks to her kindly, but Mrs. Winslow doesn’t want to hear what he is saying—something about her family moving her to Mt. Nemo. I don’t know what Mt. Nemo means, but the very words upset her. A tear slides down her cheek.

“You don’t like the idea of going there, do you?” says Adam. Mrs. Winslow answers in a ghostly whisper, as if she lacks the breath to push out the words. I feel a blush of voyeuristic shame, standing around gawking at people in their pyjamas. I look out the window instead.

“Do you have any other concerns?” he asks her. She shows that small, ironic smile again. No doubt she has concerns. Adam asks about her children, and she dredges up their names in response. They may come to fetch her today. But they’re not here yet.

Adam looks at her feet, clad in blue plastic-bag slippers that resemble shower caps. He kneels in front of her, removes the slippers, takes her bare feet in his hands and kneads them. “Does this hurt? Show me where.” With infinite slowness, like the movement of a sloth, Mrs. Winslow arduously bends forward to touch her big toe. “But your feet are nice and warm,” says Adam. “The other day you said your feet felt as if they didn’t belong to you. Remember?”

Adam, a handsome young man with a head of dark curls that would gladden my day if I were in the hospital, smiles at Mrs. Winslow. She smiles back. She seems pleased to be touched and kidded like this. She says something that neither Adam nor I can catch. He leans closer.

“I just want to die,” Mrs. Winslow whispers peaceably.

I step out of the room. When he’s done, Adam joins me, looking troubled. “The poor woman. Her husband died four years ago, and her family brought her here from Nova Scotia, away from her town and friends. She hasn’t been herself since. She doesn’t want to go to a nursing home, but there’s no place else for her to go.”

Adam makes some calls to check out her meds, and then we hustle over to the cardio ward to see Mr. Singh, an East Indian man in his 60s with an engaging smile. He’s hooked up to a heart monitor and complains of pains in his stomach. He is in the habit of wearing a blood pressure device on his wrist and checking it all the time. Adam greets him and introduces me again.

“T’m here to see if Adam’s going to become a good doctor,” I joke.

“The good doctor is the one a patient has confidence in,” says Mr. Singh, quoting Galen, and nailing my thesis as he checks his blood pressure again.

I AM WAITING IN THE DINGILY LIT SECOND CUP inside St. Joseph’s Hospital, where my sister was born. It looks as if it hasn’t been painted since then. The low-grade anxiety that people carry into these corridors hangs in the air like falling barometric pressure. Then Erin Carter strides toward me as if everything is going to be just fine.

In a dark purple sweatshirt, with a few gleams of blond in her brown hair, Erin, another second-year student, looks more like the coxswain of a rowing team than someone’s idea of a doctor. She is strong and confident, a merry, forceful talker. It is easy to see why she was chosen to perform in Med Students, a reality show shot at McMaster for the Discovery Channel. She radiates optimism without forfeiting intelligence. It’s no surprise that Erin made the cut, although she is still amazed by this.

“It’s absolutely crazy that I am in medical school,” she says loudly and cheerfully. “I cannot believe it myself.”

Erin has what McMaster likes to call “diverse life experiences” rather than a background in chemistry and biology. She applied at the age of 30, with a BA in English literature and a minor in theatre from the University of Guelph. She also had a degree in education and had spent two years teaching in Japan. When her brother, a family physician in North Bay, encouraged her to consider medicine, she spent four years as a weekly volunteer in a hospice to see how she fared in that environment. She loved it.

“I’m not a lecture person, so this kind of program suits me,” says Erin. “It’s the purest learning environment I’ve ever been in.”

Does she ever worry about knowing less than someone who has put in more classroom time?

“Yes, I’ve worked on the ward beside U of T residents, and I felt nervous that I didn’t know as much as they did, but I also know I’m on a trajectory: I have the learning skills to get better and better. What’s important is that you know what you don’t know and how to find that out. It’s just my opinion, but I feel McMaster creates weaker medical students and stronger doctors.”

LIZA’S NEXT APPOINTMENT was with her oncologist. She was more optimistic about this encounter. “He came into the room, jumped up on the gurney and was just very ordinary and affable,” she reported. (Interesting choice of words: at McMaster, students are taught that patients looks for “the three A’s” in a doctor: availability, accomplishment and affability.) The oncologist didn’t have any better news to offer than Dr. Z., but his behaviour somehow gave her hope. What was it that colleagues said about Dr. William Osler? “His very presence was healing.”

She’d had the lumpectomy, but although the cancer had been removed, the surgeon wasn’t happy with the “margins”—the cancer-free area around the tumour. Afterward, Liza had suffered little pain, but for several weeks her
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breast was very swollen. "Disfigured," was her word. A lymph node under her arm had also turned into something "the size and texture of a golf ball." This freaked her out. Meanwhile, she was waiting to get the results of tests that would tell her if all the cancer had been removed. It was an anxious time, perfect for focusing fear on any unruly parts of her body — such as a golf ball lurking in her armpit. She called Dr. Z, and requested that he see her.

"Should I be worried about this?" she said, displaying the golf ball. "It's pretty big."

"I've seen bigger," said Dr. Z, in a misguided attempt to get with the humour program. "It's normal. It'll go away."

"But can't you get rid of it? Aspirate it? It's really bugging me."

She pressed him, and he got angry. "Don't project your feelings onto me," he snapped. What feelings? Liza wondered. She was taken aback, and so was the resident in the room with them.

"He went red in the face," she told me later. "That's how I knew it really was out of line."

"Why do you think Dr. Z. said that?"

"I don't know. Maybe I was being too aggressive or acting too knowledgeable, using a word like aspirate. I just wanted him to either tell me this thing was normal or do something about it."

I was curious about the point at which the trust had gone out of this doctor-patient dance.

"Did you ever tell Dr. Z. about Paul and his experience with cancer?"

"It was the first thing out of my mouth during our first appointment."

"What did he say?"

"Nothing. Or if he did, I can't remember. It didn't seem to register."

"What would have made things better?"

Liza is the least self-pitying woman I know, but she answered with the kind of intensity normally reserved for post-mortems of failed marriages. "If he had only acknowledged me and what I was bringing into the office: years of talking to doctors, of being in hospitals, watching Paul go through chemo and radiation. He didn't recognize that I was starting at a whole different place than his other patients in this cancer game. All he needed to say was, 'I'm aware of what you've been through with your husband. I'm so sorry you have to face this now.' It wouldn't have taken any more of his time or energy."

Not even six more seconds.

THE NUANCES OF THE DOCTOR-PATIENT INTERVIEW are the focus of a new program called Patient Week at McMaster, which Cathy Risdon explains to me. Students interview volunteer patients about their positive encounters with people in the medical profession.

"The idea behind Patient Week is that by third year most students have heard a lot about what can go wrong between a doctor and a patient. They're up to their necks in potential disasters, but by that time they may have lost sight of the ideals that drew them to medicine in the first place. Yes, we need to look at what can go wrong between doctors and patients, but we also need to pay attention to and analyze the things that can go right."

Sounds like an exercise in public relations to me, but I'm game. Risdon leads me into a little room where a volunteer patient, Lori Edey, will be interviewed by several students. Most of the volunteers are from the general community, but Edey happens to be a medical educator herself. Actually, she is many things: a minister, a teacher and a counsellor. Her practice consists largely of doctors suffering from the toll that medicine can take, but in this case she is speaking as a patient. Seven months earlier, she suffered a heart attack and discovered for herself what matters when you check into the ER.

Edey is a big, blond woman in her late 40s with the kind of skin that blushes easily. For 20 years she has been researching and writing about how we teach medicine.

"The thinking behind this focus on positive experiences is very simple: what you pay attention to will grow. We adapted the idea from a business model, something called "appreciative inquiry." She gives me a "sorry-for-the-jargon" look.

"The medical model is: what are the problems here, and how do I fix it? The corporate model is: how do you build on what is already working? It's a bit counterintuitive to a lot of the students' training so far, but it works. Students are amazed that such small actions on the part of the doctor can make such a big difference."

"The thing is, there isn't enough in medical education that honours the humanity of the physician. We are just beginning to address these extremely significant issues. Medical education has been called the Yellow Brick Road. Students must go along it in search of these vital missing things...not just courage, but heart, as well."

The first student comes in. She holds her clipboard close to her. She sits down and begins to quiz Lori about her previous medical history. She has the manner of a parking attendant in a ticket booth, and Lori responds accordingly, divulging little. The student seems to be simply ticking off a box on her list rather than engaging in the encounter.

Then the next student comes in — Tracy, let's call her — and an entirely different conversation unfolds. It is hard to zero in on what this student, a young woman headed for a career in neurosurgery, does that elicits Lori's account as a vivid story rather than a list of symptoms. Among other things, the student simply comes across as a caring and attentive person. And in their to and fro, crucial new details emerged.

"My crisis was a heart attack, last fall. I'm under 50, so it was quite a shock. The doctor who made a difference was an ER doctor, Doug Richards. It was how he engaged me, right from the first, that made a difference."

"What did the ER doctor do that made things easier?" Tracy asks.

"When he first examined me, it was kind of chatty and normal. He figured out who I was and what I did pretty quickly. He just seemed like a real person who happened to have this medical expertise. You know, I thought, 'I've just had a cardiac event, but I'm not a cardiac patient.'" Lori laughs at her reluctance to see herself as a patient. "I was in classic denial. I would never have gone to the hospital if a friend hadn't urged me to go. My symptoms were atypical, the way they often are in women. I had vomited and I had a strange
sensation in my chest. I was just back from vacation, and I thought it was from dragging my suitcases around Italy.”

Tracy laughs, and Lori continues her saga.

“The first set of tests came back negative. I was all set to leave, but the doctor said, ‘You know, I’d like to run some more tests, just to cover my ass.’ He made it seem like a favour to him. So I agreed. Then the second tests came back, and I was indeed having a heart attack. In fact, I had a total blockage of one artery: it was amazing I wasn’t dead already! I might have walked out earlier if he hadn’t earned my trust. I think the trick is to maintain professional boundaries while showing your human concern.”

I was struck by the difference between the two encounters. The first student, in sticking to “the medical facts,” was deprived of the tangential, personal details that can help a valid diagnosis fall into place. The second student, using a more conversational approach, elicited a story that would help complete the diagnostic picture.

After the final student said goodbye, Lori and I talked more about her recovery. Before her heart attack, she worked 80 hours a week and loved it, but now she was trying to cut back. “I’m supposed to have a hobby, so I’m starting flower-arranging classes,” she said, “but I think that might really be stressful.”

**ANOTHER DAY, ANOTHER HOSPITAL.** It turned out that Liza would have to have a mastectomy after all, but the good news was that her life was no longer in danger. It was her first meeting with a plastic surgeon to decide whether or not to opt for breast reconstruction. Dr. Emery, a young, pony-tailed resident in blue scrubs, came in first. She was frank and mild and spent an hour and a half answering Liza’s many questions.

Physician, teach thyself: Classroom sessions like this “morning report” at McMaster allow medical students to explore subjects that arise on the ward

They described various surreal procedures in which parts of Liza’s body could be swivelled from back to front, or from belly to bosom, to fashion a new breast. Implants involve less surgery, but there’s always the risk of the highly undesirable “tired party balloon” look. This triggered some balloon jokes. The resident blushed, but seemed to welcome some giddiness in this room.

Then the plastic surgeon, Dr. Y., came in. Whew, I think, surely this is another resident and not the hallowed surgeon? She was young, with long, black hair and skinny eyebrows. Although she was a proponent of reconstruction, she didn’t push it. She was unhurried as she laid out the pros and cons of each option, one of which included doing nothing at all. Eventually, Liza arrived at her decision.

As the resident took down Liza’s personal history, her husband’s death came up. The resident paused, stopped writing and looked up at Liza. “I’m so sorry,” she said. “That’s really awful.” It was brief and sincere, and the moment passed, but something had also fallen into place.

On the way out, despite having spent three and a half hours contemplating major surgery, Liza was feeling surprisingly undefeated. “Well, that went well,” she said in disbelief, unlocking her bike. “It was almost fun.” Personally, I could think of better ways to spend our afternoon, but I was heartened. I felt I had had a brief glimpse of medicine being practised as Arthur Frank had described it: as “people in a room together, acting toward each other with varying degrees of generosity.” ☐