What if it were so easy?

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I knock gently on the door and immediately second-guess whether it was too soft. Maybe he didn't hear me. What if I don't hear him respond? Should I knock twice?

"Come in!" I hear him say.

Oh, phew.

I step in the door and announce myself with a paragraph I've been rehearsing for five minutes—tried and true, refined, yet personal. "I'm a student at the college of medicine, I'm working with the attending. Is anyone else with you today? I want you to know that I've left my pager in the other room so I can be focused on you during this visit."

That patient is an older gentleman. Short, white hair, balding. He's wearing a red flannel shirt; he was cold last time. No taller than 5'5"—big smile on his face.

I wash my hands, and shake his. "How was the drive in?" he asks me.

"Good! It was absolutely pouring this morning. You wouldn't believe it, though it stopped right as I stepped out of the car, raincoat and all. Must be my lucky day," I respond.

I try to extract his last sentence from my phonological loop. I must've completely missed it. My mind is enraptured in the many worlds of our conversation. What if he's angry? He's such a nice man. What if he's sad? What if he disagrees? What if he just stares at me—how long do I wait?

"How was yours?" I ask.

Surely my apprehension is visible. Yet he's open, expectant, attentive.

"How are your children? Any of them back home for Thanksgiving?" I ask.

"Yes!" His eyes brighten up. "Both of them. They're doing well; it's great to have them back around once in a while."

Each passing moment is patronizing. We both know why he's here, and behind cheerfully tensed crow's feet he expects confirmation. What's the point in distracting? We shook hands before the nervousness set in, and what right do I have to be nervous? I'm safe and sound, my family and friends healthy. I have stability and support. To make this about me is demeaning.

"So," I confirm, "you're here for the results of your biopsy?"

He nods, and I cannot tell if it's innocence or that he knows exactly what I'm about to say. I tell him that his results came back positive for adenocarcinoma of the lung. I watch a shadow of each stage of grief flash past his eyes in a second. He's incredulous; he's never smoked in his life.

The silence is prompt and excruciating. I want to say something, anything at all. I have to wait a moment to tell him that I'm sorry, that I can only imagine what's going through his mind, and reassure him to take the time he needs. I put my hand on his shoulder; the moment is long.

I ask him what this means to him—what he knows about lung cancer.

"It kills you," he says. "You die, you just die."

Maybe he's right, but I'm compelled to disagree. I'm compelled to be compassionate and inspire hope. But he doesn't need myopic sympathy. We sit in silence. What does he need? What do I say?

In my mind I scroll to the answer section of our text book:

A. Tell the patient to stop worrying, he's going to be fine.
B. Leave the room to call a hospital-contracted chaplain.
C. Kindly solicit the patient's understanding of his disease.
D. Give the patient alone time to process his condition by completing paperwork.
E. Contact the hospital ethics committee.

"C," I think to myself. "It's definitely C."

I have narrowly over one year of medical school under my belt. In five months I learned a brief introduction to each system while we slowly took apart a human cadaver. Just shy of that, I spent four months learning microbiology and a troupe of USMLE factoids. Right before finishing our first year, we scrambled through hematology/oncology in one month; hardly enough to learn the pathophysiology of cancer. We've dedicated only a few short hours to speaking with patients.

We practiced breaking bad news for one hour with standardized patients. I was selected to tell a man he had lung cancer—I'd been dreading the encounter the week beforehand. I thought it was formulaic, that I would struggle to be genuine. I told my roommate before I left for class, "If this were real life, I would probably cry."

Then when I began speaking with my patient, empathy overwhelmed anxiety. When I gave his results, the patient began to cry; so did I. Searching for anything to say, I referred to the SPIKES protocol from last week's lecture; I heard Kleinman urge me to elicit the patient's explanatory model.[1,2]

I tried. I struggled immensely when he told me "you just die." In that freeze-frame moment I was presented with no answer choices—following two pauses and one "tell me more," I gave in to the inclination I'd been trying to fight. The little voice that told me to pursue medicine, the desire to heal; the admirable—sometimes counterproductive—naivete I'm meant to purge while I treat a thousand noncompliant patients.

I told him that you don't just die. I told him about the team here, that we'd seen his cancer before and we'd take good care of him. That people just like him have walked away healthy. We need him to fight—and that's hard, and he needs to be where he is in this moment—moreover, what we need from him right now is trust that we will try everything within our power to help him.

After watching each student in my seven-person group fall face-first into the same trap, the psychiatrist in the room kindly told us our intentions were understandable, but our responses unfortunately are misplaced. We offered strong, thoughtful, commendable words. We were compelled to inspire hope—we want everything to be okay. Why else would we be here?

But pushback in a moment of vulnerability is invariably fruitless. Remain ever curious, the psychiatrist told us, and explore the patient's feelings. What does he know about cancer? Does he have friends, loved ones who've passed? Our optimism should not be so broad-spectrum.

This is a subtle correction—targeted and particularly memorable. I'm glad that the knee-jerk reaction of aspiring physicians is to solicit positivity; this is the "correct wrong

answer." I still remember this moment vividly six months afterward, and it stands in stark contrast to the horde of multiple-choice-questions trying their best to parrot these ideas. It's a tall ask to rescue our nuance after forcing it through the sieve of four answer choices and a paragraph vignette. We create a game of "pick the least negative option," and cheapen the principle we aim to evaluate. As a student, this is especially alarming when looking to the other end of the tunnel—where communication skills remain a notable deficit for junior doctors, particularly in the area of breaking bad news.[3,4] This is not for lack of effort on the part of educators—per recent changes to the USMLE expanding questions on communication skills, ethics, and professionalism. On the surface, this seems reasonable, assessment drives learning. Students cannot ignore these topics when they're a focal point of the most important assessment in their life.

Assessment drives learning. To assess communication and ethics in the same format as a biochemical pathway frames them as equivalent topics. It implies that there is indeed a "most correct" answer—always true for the rate limiting step of glycolysis, only true for ethics amid forced scarcity of answer choices. Looking for the "right" answer among four options rather than the world of opportunities does not encourage creativity, curiosity, or thinking broadly on the most consequential topics. When we're face-to-face with a patient, will we look for answers to rule out? Will we search for a mnemonic? Will we reach for our copy of *First Aid 2021* and page to "Appropriate Responses to Ethical Dilemmas?"

Preclinical education is a valuable space to explore these ideas. Difficult to juggle with microbiology and nephrology, but once we step foot in the clinic, our education is inseparable from the lives of others. We have only a few hours to truncate our mistakes as a learning experience. As students, in this unique and fleeting time, we must strive to fail while our education is not someone's pain. To do so, we need a space for personal, intricate, flashbulb failure, our mistakes and criticism equally intimate. One piece of feedback from a faculty mentor is more salient than hundreds of multiple-choice-questions, formative and summative. I remind myself that awareness is vital for personal growth.

Like my misplaced positivity, assessment of ethics and communication with multiple-choice-questions is well-intentioned and primarily serves to assuage discomfort with the topic. Concerns that artificial intelligence may eventually replace physicians are accurate only if physicians' actions are strictly procedural.[5] Multiple-choice-questions provide lukewarm assurance that students are aware of the importance of a subject. They manufacture a way around gray areas and "no right answers." It's no wonder such topics are relegated to the margins of the ever-widening medical curriculum. Pursuit of meaningful assessment to drive meaningful learning is as vital as it is difficult.

References

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