

SHORT WHITE COAT

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Short White Coat

*Lessons from Patients on
Becoming a Doctor*

JAMES A. FEINSTEIN, MD

iUniverse, Inc.
New York Bloomington

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Lessons from Patients on Becoming a Doctor

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Author's note: I have written the stories in this book as faithfully as possible in relation to the original events. Many of these accounts were recorded during my third year of medical school. Owing to the sensitive nature of these narratives, which rely on my accounts of interactions with various patients, I have had to alter, retrospectively, some details to remove identifying names, characteristics, and protected health information. I have referred to some patients by their first names and others by their last, and this reflects how each particular patient preferred to be addressed.

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www.iuniverse.com
1-800-Authors (1-800-288-4677)*

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*ISBN: 978-1-4401-7513-8 (sc)
ISBN: 978-1-4401-7515-2 (dj)
ISBN: 978-1-4401-7515-2 (ebk)*

Printed in the United States of America

iUniverse rev. date: 10/28/2009

For my parents, my grandmothers, and Amy

Peace. It does not mean to be in a place where there is no noise, trouble, or hard work. It means to be in the midst of those things and still be calm in your heart...

—*Author unknown*

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PREFACE

MY THIRD YEAR of medical school—the clinical year of medical school—was like most things in life that have caused me to mature internally. Before I could enjoy the validation of knowing I probably could make a career in this profession called “doctoring,” I first had to survive the rites of initiation that every medical student faces. After finishing the second year of medical school, I was required to shed my bookworm cocoon and replace it with a pristine, too-short white coat. The short white coat has come to epitomize the role of the medical student: the coat is barely long and functional enough to carry all the educational books and tools of a medical student, but plenty short and awkward enough to remind any onlooker of the partially hatched novice contained within. The transition from learning in a classroom to working in a hospital occurs overnight, and it is not an easy or painless switch. One day I sat in a lecture hall memorizing the intricacies of mitochondrial metabolism, and the next day I showed up for morning rounds terrified by the prospect of caring for living and breathing people.

This rapid transformation that takes place during the third year of medical school requires medical students to confront the many “firsts” of becoming a doctor in a head-on, no-holds-barred, full-contact kind of way. Over the course of the year, I learned how doctors cared for patients. I applied this newfound knowledge, and I too learned patient care, though usually not until I had tried many different approaches to find what worked.

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Throughout the process, I experienced my fair share of missteps, second guesses, uncertainties, and embarrassments. More often than not, these things caused me to ponder that nagging question that plagues every medical student at least a few times during the four years of medical school: “Do I have what it takes to become a doctor?”

Oddly enough, it was exactly those uncertainties, more than anything I could have learned from a textbook, that truly taught me how to help people. At first, what I had to offer my patients were the simple and non-medical things that it seemed like anyone could have provided. I learned how to fetch a newspaper, adjust a bedside tray table, regurgitate a list of lab values for the medical team, or—in the spirit of my Montessori school days—neatly clip the ends of the glorified strings commonly referred to as “sutures.” Then, as I began to gain a footing and find my place in the hospital, I increasingly functioned as a contributing member of a medical team. I learned how to take a patient’s history, discuss medication interactions with the pharmacist, make an incision into human flesh, or—what I still consider the greatest privilege given to a medical student—deliver a baby.

The amazing thing about this trial-by-fire system of medical education is that by the time I had a moment to pick up my head and survey everything I had experienced during my third year of medical school, by the time I was in a position to answer that question of questions, it was too late. I no longer wondered why the medical school admissions committee had graciously let any of my fellow classmates or me into medical school. Without exception, we had all grown into our ill-fitting, too-short white coats, and we would soon outgrow them altogether.

During my tenure in caring for people and their health, I’ve realized that the process of becoming a doctor—and ultimately being a doctor—involves a great deal of patience, humility, and, more than anything else, the ability and the desire to say: “I don’t know, but I am going to try to figure it out.” The answer might be as deceptively simple as fiddling to adjust the height of a patient’s

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tray table, or it might be as dauntingly complex as sorting through a patient's myriad symptoms to make a diagnosis. In the end, it's that innate drive to figure out how best to help people that makes all those other things—the things that made me question my decision to become a doctor—fade into the background. It doesn't mean that the difficulties associated with the "firsts" aren't valid. After all, they did fill the following pages of this book. Rather, I believe that those experiences—the good and the bad—are necessary steps in learning the art of doctoring.

James A. Feinstein, MD

INTERNAL MEDICINE

CHAPTER ONE

LINGO

“CALM DOWN, HONEY. I’m gonna help you, okay? Don’t panic. Just tell me what’s wrong.”

My lip wouldn’t stop quivering. My whole body tingled with fear. I wanted to turn around, run beyond the double swinging doors out into the open, and gulp down the cold winter air. I didn’t, though. For some reason, I trusted the operator’s voice on the other end of the receiver.

“Listen. This is what I want you to do.”

At least a half-dozen times before I arrived at this point of terror, I had attempted to page my resident according to the instructions I had scribbled down on a crumpled piece of paper. Nevertheless, each time I entered the number, the phone spit back an angry tone, signaling that I’d done something to provoke the paging system. Realizing that I was going to be late on my first day working as a medical student in the hospital, I surrendered and called the switchboard operator to help bail me out of my mess. I thought, “I’ve been in the hospital less than five minutes, and I have already become the patient.”

The previous night, I had fallen asleep expecting to wake up and start learning the business of improving people’s health, but I couldn’t affect people’s lives without knowing how to find

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them. In those moments before the voice rescued me, I had fast-forwarded to the end of the day, imagining myself still sitting in the same place, while the rest of the new medical team left the hospital after a long day of treating patients. I could almost see the quizzical looks on their faces, wondering why I—their new medical student—hadn't shown up. "He didn't know how to use his pager," the clerkship director would explain to the dean of the medical school. "He needs remediation."

The operator's soothing voice brought me back to the task.

"Punch the pound sign, eight, and then one into the keypad. This will connect you to the hospital's paging system. Can you hear the paging menu, honey?"

I followed the voice's calm directions. If the first two years of medical school had taught me anything, it was how to follow instructions. I had spent countless hours memorizing and then regurgitating chemical pathways, lists of symptoms, and treatment flowcharts. Now, it seemed like those hours had anything but paid off—I could barely dial a telephone number. Maybe those lists of diseases and symptoms and drugs had bullied away the street-smart savvy on which I used to pride myself. Regardless, I understood that nothing—not even my practical intuition—could have prepared me for my frightening, first moments in the hospital.

"Now I want you to press four to send a page. Okay?"

I keyed the number four into the phone and waited.

"Perfect. You're doing okay. Now enter your resident's pager number. Then your number. And then—this is the most important part—press the pound sign at the end to make sure to send the page. You should hear a beeping noise if it went through correctly. Do you hear it?"

I did. Then I exhaled for the first time since the operator's voice had begun to guide me through my crisis.

"Thank you, thank you, thank you," I said, in exchange for the kind woman's help.

Then, as quickly as I had let my mind spin out of control with fear, I regained my composure and felt a surge of relief rush

through my body. My lower lip quit quivering. Certain that the incident had been a fluke, I felt ready to continue with the business of changing lives.



While I waited for my supervising resident to appear, I lingered near the counter of the nurses' station. I tried to look confident, like I belonged there. Somehow, after my mishap with the pager, I couldn't calm the nervous feeling in the pit of my stomach. It didn't help that the new sights and smells and sounds of the hospital made every one of my senses uncomfortable. The rough, starched collar of my short white coat chafed at my neck. I could feel the crunch of the impeccably white fabric as I leaned against the counter. My deep pockets overflowed with medical instruments, cards with different lists of symptoms and therapies, and even a mini-textbook. Because of the weight of the pockets, I felt like I had a yoke around my neck. Every so often, someone rushed by and the resulting movement of air replaced the sharp, sanitized smell of the hospital ward with the unmistakable stench of human urine and feces. Mostly, though, I focused on the buzzing noise of a hospital whirring to life while I waited for my resident to welcome me.

Instead, a frustrated, almost angry voice punctuated the drone of the bustling doctors and nurses. A tall woman in a long white coat walked toward me, and I assumed she was my new supervising resident.

"Why didn't you answer the phone when I returned your page?"

It took me a few moments before I realized that the words had been directed toward me. Even then, I didn't quite grasp the meaning. I *had* paged my resident. I hadn't done anything wrong. The resident rephrased her question, turning it into my second lesson of the day about the nuances of paging.

"You're supposed to pick up the phone when someone returns a page! Didn't you hear the nurses on the loudspeaker system

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asking whoever paged me to pick up the phone? How the hell am I supposed to find you otherwise?”

I realized that I'd completely ignored that when you page someone, only the phone number shows up on the page—not a message, a location, or a name.

“You're lucky that I recognized you,” she scoffed.

Although I was thankful she'd found me before rounds began, I also understood the silent message in her comment: “I spotted you from a mile away. How could I miss you in your short white coat with your idiotic, bulging pockets?” Before I could consider this further, the resident took off in full stride down the hallway. I hurried to catch up with her, and as we rounded a corner, several other flashes of white now moved in sync with the two of us. My first rounding experience had officially begun.



The first visit of the morning brought us to the room of Andre Benson, an octogenarian who scowled at the medical team through his doorway. The resident cryptically began to recount the events of Mr. Benson's previous night in the hospital.

“Eighty-one-year-old male with history of alcoholism presents with DVT and PE. No shortness of breath or dyspnea. Significant lower extremity swelling. No pain overnight. Patient taking adequate PO's. PT and INR are subtherapeutic. Plan is to keep in-house until anticoagulated.”

She finished presenting her succinct update, and I could only remember that “PT” translated to prothrombin time, a measure of the blood's intrinsic ability to clot. Since PT was the single acronym I recognized during her entire presentation, I tried to peek through the doorway and visually assess for myself why Mr. Benson had ended up in the hospital. I couldn't see anything but his now sullen face poking out from underneath the layers of hospital blankets, and by the time I had turned my attention back to the team, they had moved on to another room.

Once again, I jogged down the hallway, my pockets swinging with each stride, and I tried to decode and process the remainder of the resident's assessment of Mr. Benson's health. I wondered how I would ever survive the next hour of rounds, if for no other reason than I was not physically fit enough to keep up with the rest of the Olympic-fast team.



When I started medical school two years earlier, no one told me it would be the most difficult experience of my life. Although my senior classmates had acknowledged that the first two years of basic science courses would shake the most confident student, this was always trumped by the notion that the final two years—the in-hospital, clinical years—would make everything worthwhile. “When you stand in front of a patient, all those hours of memorizing and cramming will pay off,” they had said, unanimously.

Indeed, they had correctly predicted the course of my first two years of medical school. On several occasions, I found myself basing my self-worth on a few lousy numbers, and I routinely wondered why in the world I had considered myself fit for the medical profession. Only near the end of my second year did I acclimate to the challenging environment, once I learned to place emphasis on the process of learning, rather than on my grades. Unfortunately, just when I started to become comfortable with one topic or experience, the medical education system always managed to drag the rug out from underneath my feet, throw me into a new situation, and leave me feeling overwhelmed and unsettled. I'd just mastered how to dissect a cadaver when we moved on to a completely separate task of learning how to examine a living patient. Even though I'd come to expect these kinds of transitions, I never thought my introduction to working in the hospital would be so jarring.

In the days leading up to that first morning in the hospital, my friends, and family had affirmed that I had arrived at the

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doorstep of my calling: “You’re meant to be around people. You’re such a good listener.” I was embarrassed for believing their ego-stoking words. I couldn’t dial a pager number. I couldn’t follow what seemed to be a routine presentation about a patient. I didn’t believe I would ever appear—or feel—confident enough to take care of patients. With my pockets swinging as I ran after the team, I somehow felt I deserved my position at the end of the line.



Outside the next patient’s room, the resident reported to us that the Emergency Room (ER) had just sent the patient, Estelle Grady, to our ward for evaluation of a suspected MI. This time I recognized the abbreviation instantly: myocardial infarction—heart attack. Having just finished the basic science course in cardiology, I was determined to keep up with the discussion.

The resident proceeded to tell us about the patient’s past medical history, then the events leading up to Ms. Grady’s trip to the ER, completing her presentation with Ms. Grady’s laboratory results.

“Her first and second CK’s were normal. Her first troponin was zero point three.”

These words were more familiar. Even though I didn’t know how to interpret the values, at least I recognized the terminology. As we moved on, I walked alongside the rest of the team, and I nodded my head at their comments about Ms. Grady’s condition.

After rounds ended, the attending physician—the boss of the team—pulled me aside. I felt certain I was about to receive another lecture on paging etiquette or a directive to go to the gym to get in shape so I could keep up with the medical team on rounds.

“I noticed that you seemed to take an interest in Ms. Grady’s case. I think that the workup of a myocardial infarction is good

bread-and-butter medicine. Do you want to follow her as your own patient?"

Elated, I could only nod.

"Good. Why don't you follow Mr. Benson, too," the attending physician said. "Oh, and when you go back to see Ms. Grady, tell her that her repeat labs were negative. You can also let her know that as long as the next set comes back negative, we'll plan to send her home tomorrow morning. She'll be able to follow up with her own doctor to monitor her condition."

A surge of purpose rushed through my body as I took off toward Ms. Grady's room.



As I sat by Ms. Grady's bedside, I was determined to figure out the cause of her chest pain. Maybe if I did, I would impress the team enough to make up for my athletic shortcomings earlier that morning. I questioned her about the various things that might have precipitated her chest pain.

"Were you doing anything different when the pain occurred?"

I felt confident as I ran through the list of symptoms that I had memorized during the first two years of medical school.

"How about a history of chest pain or heart trouble?" I continued. "Asthma or breathing problems? Heartburn or reflux?"

Once I completed the interview, I tried my best to perform a cardiac exam on Ms. Grady. I listened to her heart and examined her pulses. Then, as instructed by the attending physician, I began to speak with her about the results of her cardiac laboratory tests. The confidence in my voice surprised me.

"Your last troponin level was zero point three. If your next troponin level is the same, then you might be able to go home tomorrow," I said. I used my most doctor-like voice, and I recited almost word for word what the attending physician had told me.

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Instead of a look of relief, I recognized the unmistakable quivering lip of a terrified patient. I had anticipated that the promising test results would put Ms. Grady at ease. It caught me by surprise that she appeared more worried than before. As tears welled up in the corners of her eyes, I panicked. What had I said to make her react in this way?

I uttered the same universal, no-nonsense question the phone operator had asked me just a few hours earlier.

“What’s wrong, Ms. Grady?”

After a moment’s hesitation, she began to speak.

“Honey, I don’t know what ‘tronins’ are. But you said I have them—zero point three of them. Does that mean that my heart is bad?”

Immediately I realized my mistake: I’d assumed the stereotypical role of a doctor. I was caught up in scientific terminology instead of communicating the information most important to Ms. Grady. I wondered how I had forgotten the helpless feeling I’d experienced that morning while my resident spewed foreign medical terminology.

“I’m so sorry,” I said. “Troponin levels help us to identify when a person has had a heart attack. Your troponin level was zero point three and that’s completely normal. Everyone has a bit of troponin floating around in their bloodstream, even with a totally healthy heart.”

Ms. Grady looked less panicked.

“So, no, your heart isn’t bad,” I said.

Picking up her dining menu, I drew the rough outline of a heart, illustrating how a heart attack caused the release of little bits of troponin into the bloodstream. Ms. Grady confirmed each of the steps with a “Mm-hmm,” and when I finished with my explanation, I noticed that her bottom lip had quit quivering.



Early the next morning, before rounds began, I visited both of my patients to see how they had fared the night. For no particular reason, I decided to visit Mr. Benson first.

“Hey, Doc,” he said cautiously as I entered his room.

Almost reflexively, I blurted, “I’m just a medical student, Mr. Benson.”

“Medical student. Doctor. Whatever. You’re all the same to me—a bunch of shysters. Just tell me how my blood is this morning. Can I go home?”

I had already checked the results of his coagulation profile that morning. Having read up on the subject the previous night, I knew his numbers suggested that his blood thinning medication had yet to kick in. Nonetheless, knowing my current place at the bottom of the chain of command, I swiftly dodged the question.

“I’m not quite sure yet. Your PT is thirteen and your INR is one, but I’m still learning how to interpret the values. It’s better if the rest of the team explains what those results mean.”

Although unspoken, I think we both realized that Mr. Benson would probably spend many more days lying in wait until the team could discover what had caused the clot in his leg. Upset by my avoidance of his question, he turned back to the blaring television as I sheepishly walked out of the room. I felt like I had deceived Mr. Benson by hiding behind the same abbreviations and numbers that left me confused and unsatisfied the day before.

Ms. Grady’s room was a few paces down the hallway. I leafed through her chart, which lay on a counter outside her door. I began to review her vital signs, but before I had the chance to read her laboratory values, I heard her calling from inside her room.

“Good morning, Doc!”

I walked in and found myself correcting her in the same way I had Mr. Benson.

“I’m just a medical student, Ms. Grady.”

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“You ain’t *just* anything,” she said. Her radiant face told me that something good had happened since I’d seen her last.

“Honey, my ‘tronins’ came back normal!”

I matched her smile with one of my own.

“The nurse told me my last level was point zero three. I’m gonna be A-okay.”

Me too, I hoped. I squeezed her hand, adding, “The rest of our medical team will be back soon so we can talk about getting you home.”

Then I walked out the door, located a phone, and paged my resident, eager to see the remainder of the day’s patients.

CHAPTER TWO

ANAPHYLACTIC SHOCK

LIKE BEING IMMERSED in any foreign culture, a week or two in the hospital was all I needed to notice the local customs and practices. Thus far, I had learned that the main responsibilities of a medical student consisted of picking several patients to follow during their hospital stays, presenting these patients' histories to the medical team each morning, and preparing mini-reviews on the most current research regarding these patients' illnesses.

Lore existed among my fellow medical students that these presentations had to be as polished and flawless as a presidential address—our entire medical worth depended on them. At the end of each presentation, the medical team sized up the medical student by asking questions designed to make sure a medical student understood his low rank. This humiliating process directed toward medical students was commonly referred to as “pimping.” Thus, in a survival of the fittest kind of way, medical students would gather and hoard patient information so that each one of us might somehow deliver the perfect, complete presentation and achieve the holy grail: a plain and silent nod of approval from the attending physician.

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I noticed that each attending physician seemed to have his own set of preferred questions that he asked about a patient's medical history—regardless of the patient's actual symptoms or diagnoses. Some of them wanted an exhaustive account of a patient's past travel history. Others wanted a detailed analysis of a patient's use of seatbelts and bicycle helmets. Given that a new attending physician assumed control of the ship every two weeks, with new residents every four weeks, the possible combinations of their pet preferences seemed dauntingly endless.

As absurd as some of the requests for information sometimes seemed, I nevertheless began to realize that the more patient information I collected up front, the better prepared I would be to answer any questions thrown at me. I turned interviewing patients into a game of collecting every scrap of information. Then, when an attending physician inevitably asked some esoteric question, I could answer coolly and without hesitation.

“Has the patient ever taken a sulfa drug in his whole, entire life?”

“Yes.”

“What is the patient's favorite food?”

“Pizza.”

“What is her shoe size?”

“Eight.”

Amid a sea of constant change, my exhaustive interviewing technique afforded me some protection against an unexpected question.

After introducing myself to Erich Allen, a new and somewhat frightened patient lying before me, I skipped the small talk of introductions, and for the sake of efficiency, launched directly into a full-blown interrogation. I scrolled down my mental checklist, making sure to collect any tidbit of information that the attending physician might deem necessary to Mr. Allen's care. By the end of my cross-examination, he looked completely exhausted. I took the opportunity to excuse myself, and I exited his room so I could get a head start on preparing my presentation.

Later that night, unable to sleep because of an overactive heating vent in my overnight call room, I began to pace the empty hospital hallways while practicing my presentation in my head. I meticulously pieced together the information Mr. Allen had supplied, and I took care to include every relevant fact. By the time rounds began the following morning, I convinced myself that I had perfected a bibliography of Mr. Allen's life so complete that the attending physician wouldn't have to ask a single question.

We approached Mr. Allen's room, and I confidently wove my way to the front of the crowd of long white coats. I cleared my throat and prepared to deliver my presentation. But before I could get any words out, I realized I had forgotten my patient's name. A wave of fear swept through my body. I stood in shock, my heart pounded, and I wondered how I had managed to get myself into this situation. I had been so focused on anticipating the attending physician's questions, that I had lost sight of the patient. My eyes scanned the blank faces attached to the long white coats. They waited. I frantically looked around the room, and my eyes searched for something that might remind me of my patient's name—and then I found it. On Mr. Allen's pale wrist sat a neon orange hospital bracelet, its inscription just barely legible from where I stood. With a renewed confidence, I began to speak.

"Everyone, this is Mr. Shellfish. He is a sixty-two-year-old male with a past history of hypertension, diabetes, and—"

I heard a rumble beside me. I continued reciting his medication list before I realized that Mr. Shellfish had erupted into a giant, full-bellied fit of laughter. His chest heaved beneath the thin, white hospital gown, and his shrieks of amusement filled the room. I couldn't hear anyone else laughing, which perplexed me. Had I forgotten to inquire about a psychiatric history? The patient hadn't seemed delirious that morning during pre-rounds.

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I did the only thing I could, and I pushed onward with the presentation. But I stopped once I began to recite the patient's list of allergies—Mr. Allen had an allergy to shellfish.

I stood mortified before the medical team, stuttered for a few moments, and then finished the remainder of my presentation. At the conclusion, I followed the team out of the room with my tail between my legs. As I had done that first day in the hospital, I tossed my visions of residency into the wastebasket next to Mr. Allen's door. Once again, those feelings of inadequacy surfaced. How would I ever take care of multiple patients when I couldn't remember *one* patient's name?

Luckily, the attending physician chose to ignore my blunder. Instead, he began peppering me with questions about Mr. Allen's travel history and his favorite hobbies. The practiced answers rolled off my tongue, although that day the attending physician's affirmative nods failed to excite me. I stood there like a fraud and thought that anyone could have filled my shoes.

After rounds ended, I felt an urgent need to apologize to Mr. Allen. When I walked back into his room, three unfamiliar faces looked up at me. A woman seated at his bedside stood, beamed, and offered me her hand.

"Hi, I'm Mrs. Shellfish and these are our two children," she said, motioning with her hand. The four of them burst into uncontrolled laughter. I cast my eyes downward, smiled sheepishly, and then succumbed to the humor of my mistake. After a few moments of levity, I turned my attention to Mr. Allen and apologized for having forgotten his name. Once he caught his breath, he looked at me and spoke.

"Shhhh. You don't need to apologize for anything, son. I haven't laughed like that in weeks—although I'm sorry that no one else got your joke. Keep it up. You're doing just fine."

I wish I could say I was a completely changed person following that incident, but I wasn't. In my short tenure as a third year medical student, I realized that my instructors would continue to evaluate me on the answers I supplied to some of their innocuous

questions. And, because attending physicians were never going to stop asking questions, I still needed to collect every bit of information from a patient, despite having just learned firsthand the inherent dangers in doing so.

The difference in my actions, I realized, needed to occur in the way that I collected the information. During the next several weeks, I deliberately devoted less and less time to crossing off mental checkboxes, and instead, I talked more freely with each of my patients. Not surprisingly, once I made this transition, I found myself learning and remembering more about my patients' lives than I had during my first few weeks in the hospital. While I still wasn't able to answer every obscure question that an attending physician directed at me, I did find myself becoming more comfortable with the phrase, "I don't know"—if for no other reason than because I knew my patients and their names well enough to go back for a friendly visit and find out the answer.