least as difficult as calculus, but it must be learned rigorously from the moment of entry into medical school; neither basic science nor the data from clinical trials should be presented in isolation from clinical problems nor separately from a rigorous decision-making process.

George D. Sweeney, MD
Faculty of Health Sciences
McMaster University
Hamilton, Ont.

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[Frank Davidoff replies:]

Dr. Sweeney has put his finger on an important "missing link" in the great chain of medical evidence: the lack of adequate teaching. For although a few controlled studies[1] have demonstrated the effectiveness of teaching rigorous approaches to clinical reasoning (including Bayesian analysis), the science of clinical decision-making still receives far less recognition in medical school and postgraduate curricula than it deserves. Unfortunately, enthusiasm for such teaching is dampened by the difficulty of applying our current formal decision analytic techniques at the bedside (an experienced consulting service at Tufts-New England Medical Center in Boston found that most full decision analyses of individual clinical decisions required about 2 weeks of effort by a clinical fellow [personal observation]). It may be more realistic to think of decision science as an imaging technique for visualizing medical reasoning[2] and employ it as we do other basic sciences such as anatomy, rather than as a clinical science such as surgery.

Our lack of understanding of the role that basic biological knowledge actually plays, and the role it should play, in clinical work is little short of scandalous. The small number of studies that have examined this question empirically have concluded that the use of basic biological knowledge by experienced clinicians is minimal and indirect.[3] Sweeney is therefore quite justified, I believe, in questioning whether basic science, at least as we now teach it, is a necessary part of medical education.[3]

Frank Davidoff, MD
Editor
Annals of Internal Medicine
Philadelphia, Pa.

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Med students as emotional chameleons

Everybody knows about the long hours, late nights and gruelling obstacles that medical students endure, but few outside the profession are aware of the emotional challenges that accompany the medical school experience.

A few months after completing a seminar aimed at teaching the importance of empathy, listening skills and understanding a patient's social context, I watched a pathologist dissect a person who had recently died. After feeling this patient's warm heart in my hands and thinking about what his life might have been like, I asked, "Did he have a family?" The response consisted of a furled brow and a mocking glance. Several months later, during a family medicine rotation, I was criticized for not showing enough sympathy toward a teenage girl who had recently begun taking oral contraceptives and was complaining about weight gain.

These early experiences marked the beginning of my confusion about which patients, in which specialties, I was expected to care about. During my general surgery rotation, I was told to spend less than 10 minutes assessing an alcoholic street person who had been stabbed by a prostitute. A month later, in psychiatry, I was expected to explore the psychodrama, including childhood abuse, sexual fantasies and feelings of anger and abandonment, of a depressed middle-aged man, in no less than 60 minutes.

I became increasingly unsure of when I could express my true compassion, when I would have to manufacture concern, when I was expected to offer psychological support and when I would be ridiculed for being too caring. But the exhaustion, the daily (and nightly) tasks of each rotation and the need to plan for my future prevented me from addressing these issues during medical school. Only in retrospect do I realize how I, like so many eager medical students under constant surveillance, had shuffled through medical school from one rotation to the next, feeling like an emotional chameleon.

Experiencing a variety of rotations is a fascinating part of medical school. But each specialty has distinct and unspoken expectations regarding the extent to which its practitioners should engage in patients' emotional lives, and trying to modify one's very human responses to match a specialty's subtle customs can be an odd and stressful experience. I entered a residency program in psychiatry because I enjoy dealing with patients' psychosocial issues. I hope that open

discussion about this unfortunate quirk of medical training will help students to feel less "schizophrenic" (literally, divided) and to make appropriate and satisfying career choices.

Ariel K. Dalfen, MD
PGY1, Psychiatry
University of Toronto
Toronto, Ont.

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