# Getting the Right Medical Students — Nature versus Nurture

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The video shows a fourth-year medical student interviewing a patient. The student is a bit awkward and is using technical terms and inappropriate body language. A leading medical educator asks, "How did we let this student into medical school?" "Wherever I travel," he continues, "I hear from public officials that doctors demonstrate little empathy and don't communicate well with patients. We have to fix the problem. We have to screen for more humanistic students in our admissions processes."

With many patients complaining about doctors' poor interpersonal skills, it's hard to deny that there's a problem. No admissions process is perfect, and some students admitted to medical school may well demonstrate little empathy or lack the requisite communication skills to be effective doctors — but is that the primary cause of the problem? That assumption has spawned a movement toward new interviewing techniques and admissions policies. "Holistic admissions," which aim in part to enhance the diversity of the medical workforce, and the "multiple mini-interview" process are becoming increasingly prevalent. To the extent that these approaches attempt to determine whether applicants have a strong understanding of ethical issues, concern for underserved populations, and appropriate communication skills, they are held out as significant steps toward graduating doctors who can relate to patients.

Efforts have also been made to revise the Medical College Admission Test (MCAT) to assess students for similar attributes, or "personal competencies," with the goal of screening out students deemed to lack such qualities. The addition of an MCAT section covering behavioral and social sciences reflects the consensus that greater exposure to these disciplines in college will produce medical students with increased insight into the human condition.[1]

Selecting the "best" students to admit to medical school is challenging, and admissions committees welcome new ideas on improving the process. But aside from being resource-intensive, some recent innovations have led education professionals to embrace a false dichotomy: Would you prefer your doctor to be smart or an empathetic communicator? Personally, I want my doctor (and my students) to be both. I believe that the causes of current problems in doctor–patient interactions are more complicated than this formulation implies, and we should question the assumption that we're admitting the wrong students — and consider alternative solutions.

Typically, students enter medical school idealistic, eager to improve the human condition, and excited about becoming doctors. And then we do various things to change them. We have them memorize long lists of facts (or at least they perceive that as our goal), delay their involvement with patients, and expose them to frustrated and overwhelmed faculty members who are under increasing pressure to generate greater clinical revenue. And students' empathy diminishes.[2]

Fortunately, curriculum reform is under way at many medical schools to combat some of these problems, and some data suggest that the erosion of humanistic qualities can be prevented.[3] Earlier clinical experiences are becoming more prevalent, and techniques such as "flipped classrooms" are making classroom activities more engaging and relevant.

Despite these changes, some students will not demonstrate competence in their interactions with patients — what then? Historically, less than 3% of students who enter medical school have failed to graduate for academic reasons.[4] My first question about the student in the video described above was, "How did he make it to the fourth year of school?" Communication and interpersonal skills are a core competency; if a student doesn't demonstrate that competency, remediation efforts should be made, and if they fail, the student should not be permitted to graduate. But medical school faculty are loath to fail students. It's been suggested that we view our duty to students as similar to our duty to patients: we never abandon them. Or perhaps we worry because medical students have typically incurred substantial debt by their third or fourth year; what will become of them if they don't graduate? Fear of legal battles arising from failure to promote or graduate students lacking in less easily quantified skills, such as communication, also plays a role. Regardless of the reasons, if we are graduating doctors who are incompetent to interact with patients, we have only ourselves to blame.

Yet what happens to students who graduate with their compassion intact and are able to communicate effectively and sensi-



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**Approaches to Sustaining Compassion and Communication Skills in Medical School**

- Implement curricular changes that support students' idealism, kindness, and focus on patients, such as providing earlier clinical experiences or requiring participation in student-directed clinics.
- Select clinical faculty for their ability to support the desired values.
- Refine measures and instruments for assessing interpersonal skills, support faculty in completing these assessments, and prohibit students deficient in the necessary skills from advancing in their training.
- Advocate for financial and logistic systems that enable doctors to spend more time with patients.

tively with patients? Our system forces them to have time-constrained patient interactions that challenge even the most caring doctors to apply their training.

Recently, for example, I was scheduled for a 20-minute ambulatory care visit with a middle-aged woman with a rheumatologic problem and evidence of new cardiopulmonary complications; she had last been seen a year earlier. I greeted her in the waiting area and brought her to the exam room, where she told me that her husband had recently been diagnosed with cancer and was scheduled for surgery the next week. She was tearful, distraught, and concerned about her family. I responded to her emotions, consoled her, validated her experience, and inquired about supports available to her; we were now 13 minutes into the visit. We then discussed her symptoms and functional status, and I reconciled her medications. Then I had her change into a gown, I examined her, and she dressed; we were now 20 minutes into the visit. I reviewed her recent test results, answered her questions, and discussed next steps. She finally left the exam room 35 minutes after arriving, and I was seriously behind schedule, leaving subsequent patients pondering the delay.

If I'd been accompanied by a student, how much longer would the visit have lasted, as we debriefed about it? Would I have felt such time pressure that I would have been compelled to "just get the work done," leaving the student disillusioned? In my experience, every ambulatory care session is punctuated by at least one patient with extra needs. How does one make up the time? Are we really surprised that doctor–patient communication is problematic given the system in which we work?

If we're going to improve interactions between doctors and patients, I believe we must do more than refine the medical school admissions process — a focus that sends current students the message that they might not be "right" for medicine — and devote more time to the things that truly interfere with students graduating with and sustaining the appropriate attitudes, compassion, and skills (see box).

First, we can explicitly celebrate and support the idealism, kindness, and patient focus with which students enter medical school. In addition to the curricular changes now under way, we could consider requiring participation in student-directed clinics, since these experiences can often sustain the qualities and values we seek.[5]

Second, we can ensure that the clinical faculty who supervise our students are selected for, and trained to enhance, their ability to support rather than undermine these values; faculty members who model and perpetuate poor behavior ought not be allowed to interact with students. We can make it clear that teaching students is a privilege and that we have high expectations for those chosen for this task.

Third, we can continue to refine objective measures and instruments that enable faculty to assess interpersonal skills, provide faculty development to ensure these assessments are completed, and prohibit students deficient in the skills necessary for patient-centered care from advancing in their training. When teachers document student deficiencies in these areas, we can support them through the difficult times that may ensue, as students protest the assessments.

Finally, we can continue to work at the policy level to create the systems, financial and logistic, that enable doctors to spend the time with patients that is required for effective communication. The most discerning admissions process followed by ideal training will still fall short of our goals if the reality of daily practice prevents doctors from establishing meaningful relationships with their patients.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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