Stephanie Sterrett, a first-year medical student, wonders if she will be able to establish rapport with her patient, Randall Lee, a wiry man with graying hair, a Baptist who doesn’t drink or smoke, a 59-year-old owner of a construction business.

Actually Lee is not a real patient, but an actor playing a role; he sits alone at the front of a small room in the University of Pittsburgh School of Medicine’s Scaife Hall. Sterrett approaches him and, in lieu of a door, knocks on a table, around which her classmates are gathered. Several of the students have already interviewed Lee, each building on the information gathered by the others. She sits down and explains to Lee that she knows about his occasional symptoms—numbness, a vibrating sensation in his abdomen, and increased gas. “Have these symptoms been worrying you lately?” she asks.

“As they continue, yes,” Lee responds in a slow, Southern drawl. “Has this impacted your life in any way?”
“No, I’m pretty busy.”

In this first-year Patient Interviewing Course, students spend most of their time interviewing “simulated” patients. The seven-week course allows students to practice skills essential to taking a patient’s history, such as gathering accurate, detailed information, fostering patient openness and trust, and responding to a patient’s emotions, says Laurel Milberg, course director. “It’s trial and error, experiential learning,” she says. “The goal is practice, practice, practice.”

Sterrett asks Lee if he has any idea what is causing the symptoms, and if he has talked to anyone about them. “Are there any other problems you’ve been having with your health lately?” she asks.

“Well, I did, probably in March, see a doctor,” Lee says. “I found that when I would urinate, I would get this sort of ache at the base of my penis, and I noticed that, there was some, would appear to be some form of dribbling.” Lee tells how he visited a physician friend who said the problem had to do with his prostate; the friend prescribed a drug that cleared up the symptoms.

Sterrett calls a time-out to seek advice. “I don’t know where to go,” she says, her voice full of high-pitched energy.

“It seems a little sketchy, ’cause he saw his friend. It doesn’t sound like he actually figured out what it was,” says a classmate near the front of the room.

“I would go a little more into the prostate thing,” adds another.

“He tells you something which may be a sexually transmitted disease, and what are you thinking about?” asks Paul Needle, an instructor for the course.

“Oh, no,” Sterrett says. The room fills with laughter. Now everyone is talking at once. The discussion turns to ways to raise sexual issues with Lee.

“Well, say, How is your marriage? And then go to, Are you having any problems with your marriage?” offers one.

“I am just really blunt, and I’m just afraid I’m going to offend him,” Sterrett says.

“Do it in a way that’s comfortable for you,” Needle says.

Sterrett ends her time-out. She asks Lee if he is away from home a lot on business. She builds up to her question delicately: “Did you have other sexual partners while traveling?”

“Oh, ah, hah. Let me make it very clear that I am a Baptist, and I would never, ever have a relationship with another woman outside of my marriage. No, no. The answer to that is no.”

Needle calls a time-out to make a point.

“What was his answer to your question? What were his words?” Needle asks.

“Relationships with other women,” Sterrett says, laughing softly.

“But, if he’s a Baptist, maybe it doesn’t even occur to him to like, acknowledge that,” posits a classmate, referring to homosexuality.

Sterrett cringes at the thought of broaching the subject. “Well, how am I going to ask him?”

“Have you ever had sex with a man?” Needle offers.

“Well, the answer is yes,” Lee says, rubbing his palms across his eyes. “I’ve only had three experiences. It’s happened once a year for the last three years. I seem incapable of stopping it. I fear, I fear that these symptoms may have something to do with something like AIDS or something.”

“We can find that out,” says Sterrett. They discuss his fears. She ends the interview.

“Wow. That is not even something I would have even picked up on. That was pretty much the whole main reason for his being here,” Sterrett says. “He could easily have lied and denied it, but I think he wanted to get it out.”

Needle encourages her to find out more about the thoughts of this character, “Randall Lee.” The actor, Bruce Hill, a Pitt drama instructor, is still in role. Out of a sketch of a man—traits, symptoms, and psychosocial issues—Hill has developed Lee into a full-fledged character; he knows his thoughts, feelings, reactions. Sterrett asks Lee if he was gratified to speak.

“The truth is that I’ve been to other doctors, and I’ve wanted to discuss it, but I’ve not been able to,” Lee says. He reveals his desire to talk and his fear. “Just by sitting there and being quiet, you let me reach my own decision,” he says. “It made it easier.”

“METHOD PATIENTING

“No death or dying or major anger,” urges Kenneth Gargaro.

Gargaro, a theatre director, trains actors to be simulated patients. He is giving a pep talk to 16 actors, who will portray patients for first-year students in today’s Patient Interviewing Course. In the next couple of weeks, Gargaro’s cast will “have” a gamut of illnesses, including stroke, panic disorder, diabetes, lupus, and gastrointestinal bleeding. Today, however—no matter how inspired the actors may be—death and dying and major anger will not emerge as issues with which the patients are grappling. That happens in the final two weeks of the seven-week course. For today’s class, week five, emotions surface as the student interviews the patient, but they are relatively mild—suspicion that symptoms may mean a serious illness, embarrassment over sexual matters, resentment about having to speak to a young medical student. The students learn to respond to less-intense emotions before tackling the severe ones.

“The students need to identify that emotion, they need to understand it, they need to respond empathetically,” says Gargaro. —DH
the prognosis for the 83-year-old man is bleak, and he’s thinking, again, about what that really means. When his wife came in this morning, she left with him a brand new photo of his great-granddaughter, which he holds in his hand now. She is kneeling with a soccer ball, flashing a big grin. He adores that little girl, but probably, he’s never going to see her play a game. In a few years, maybe she won’t even remember her great-grandpa. His wife tells him it’s awful to think such things, but he can’t help it. He turns the photo over and places it on the edge of his bed. He’s tired.

He doesn’t notice that his doctor has walked into the room. It appears that the doctor hardly notices him either: His eyes are focused on a medical chart.

“I need to ask you a few questions,” the doctor informs him. “If your heart stops, do you want us to restart it, and if your blood pressure gets low, do you want me to put you on medicine to raise it?”

The patient has no answers, only questions. Is he about to die at any moment? Has the doctor given up on him? Should he give up on himself?

Robert Arnold will tell you that this scenario could, and should, have gone differently.

Arnold, who is a professor of medicine at the University of Pittsburgh School of Medicine, suggests another way the physician might have broached these end-of-life issues: “What if the doctor had said, ‘What are your concerns and fears? When you think about the future, what do you think about? I think the doctor would have had a very different discussion with that patient.’

It’s this kind of dedication to a more meaningful and humane dialogue that led to Arnold’s appointment last July to the Dr. Leo H. Crip Chair in Patient Care. The chair’s namesake, who died in 1992, taught at the University of Pittsburgh for 50 years and was the chief of medicine at UPMC Montefiore and a renowned allergist. Arnold knew him personally. “He was very beloved by his patients,” says Arnold, “and very interested in both doctor-patient communication and doctor-patient relationships and the influence each has on medical care. He was concerned a great deal about how the transformation of medicine through technology might undercut that relationship.”

Hence, the Criep family worked with school officials to create what is believed to be the first endowed chair in a medical school with a mission to nurture the multi-faceted connection between doctors and patients.

The kinds of difficulties patients and their families go through made an impression on Arnold himself when he was just a boy. His older brother had leukemia and died when Arnold was about 5-years-old. “I don’t remember very much about the doctors,” he says. He remembers the hurt, however; his eyes well up at the mere mention of the heartache. That’s when Arnold started thinking about becoming a doctor.

After high school, he enrolled in the University of Missouri’s six-year medical school program. He majored in philosophy because, in part, he says, “the biology and chemistry courses were boring.” During his freshman year, he took a course in medical ethics and was intrigued by the issues it raised. Today, it’s part of his job to make sure Pitt’s curriculum addresses such topics.

Lessons about doctor-patient communications—which could focus on issues as seemingly simple as learning to listen—aren’t taught with lectures. Through discussions of cases like the elderly man being questioned about end-of-life measures, Arnold hopes to instill skills that have little to do with a scalpel: “Some may view what I teach as common sense. Anybody can talk. But the truth is, we’re not very good at talking to each other.”

When it comes to matters of the heart, there are no right answers. Yet, notes Arnold, “The fact that there is no right answer does not mean there are not wrong answers.”