Introduction to “A Detour for Leah”

The fifth annual Association for Academic Psychiatry (AAP) medical student essay contest continued to be a vigorous competition in 2009. This year’s theme remained “The Art of Communication in Psychiatry: Connecting with the Patient,” within the overall framework of “On Becoming a Doctor.” The contest is open to current medical students who will continue to be enrolled students through the time of AAP’s Annual Meeting in the fall. Students submit essays of up to 2,000 words that focus on the themes above. The award consists of free registration and reimbursement of reasonable expenses for the Annual Meeting, and is funded by an anonymous donor. The aim of the competition is to encourage students to engage in academic medicine and to further develop interests in psychiatry and interpersonal aspects of patient care. (Additional information is available via the AAP website, www.academicpsychiatry.org.)

Essays are judged by a panel of AAP members blinded to authorship and following a scoring rubric. Literary quality, uniqueness, and appropriateness to the theme are valued. This year, 13 essays from medical students across Canada and the United States were scored, with many of very high quality.

The 2009 AAP “On Becoming a Doctor” Essay Contest winner is Devon Quasha from Harvard Medical School. Ms. Quasha presented her essay, “A Detour for Leah,” at the AAP Annual Meeting at the end of September in Washington, D.C. The essay thoughtfully raises issues of mentorship, professional development, and humanity, among others.

Martin Leamon, M.D.

A Detour For Leah

Devon Ronan Quasha, J.D.

We’d just sat down when the pager went off. My intern laughed. “Another delightful dinner,” he said, as we grabbed our food and left the cafeteria.

It was a Friday evening in November and my second week on 9 East, a pediatrics inpatient service. My intern, Dan, and I were on call. We had to get sign-out on several patients being transferred to our service.

The resident giving sign-out flew through the first few. She paused at Leah.

“Oh,” she said, her voice soft. “Leah Smith. She’s a 3-year-old female with a rare metabolic disorder. She’s now comfort-measures-only, but the plan is for her to go home soon. We’re not sure she’ll even make it to that point but, basically, we do whatever the parents want.”

Dan looked up from his notes. “Ok,” he said. “Is there anything we should do if she dies?”

“Yes,” she replied. “It’s important to Leah’s father that an autopsy be performed so more can be learned about Leah’s disease. Because it’s a metabolic disorder, the autopsy has to be done shortly after death. The palliative care team has a plan, so page them the moment Leah dies. They’ll handle it from there.”

She continued, “Honestly, the parents are really difficult. The father is in denial, and the mother is pregnant and so depressed she barely talks. We spend as little time in that room as possible. And, be forewarned: once you’re in, you’ll be an hour.”

I swallowed. My team was caring for several chronically ill children. They were easily the most dispiriting patients I had ever encountered. We hadn’t had a dying child, however. Even more, we hadn’t had a family, or situation, that was so difficult that the team intervened as little as possible.

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After sign-out had ended and we’d eaten, Dan and I discussed the evening’s plan. We had two new patients to admit, six to check on, and a list of sundry tasks.

“Ok,” Dan said. “You do the first admit and check on Jones and Roberts. I’ll do the rest, and we’ll meet back here to take care of the other stuff.” He threw away his plate and walked to the door.

“Sure,” I responded. “But what about Leah? Are we going to visit her tonight?”

“Oh,” he said, sounding surprised. “No, no. There’s nothing to do there. And, it sounds like we’ll never get anything else done if we do anyway.”

With that, he left.

I am a fourth-year medical student. Like those before me, I’ve lugged the surgical bucket from floor to floor, dashed to the radiology reading room to get a wet-read on a CT, and scribbled the umpteenth note for the laboring patient. “Becoming a doctor” has, however, felt more like an exercise in contradiction than in anything else. I’ve found the philosophy of medical education, and doctoring more generally, to be often at odds with the reality of the wards. During the first 2 years of medical school, we are reminded of the humanism of medicine and of the importance of the core relationship between a doctor and her patient. Then, we hit the wards. There, there is no time for Leah, no opportunity for real communication. This conflict invariably plays itself out within each of us: we, the idealistic medical students, come to medical school filled with a belief in “the individual”—in ourselves and in our future interactions with our patients—and we imagine a future filled with meaningful relationships. As we become subject to the constraints and stresses of actual doctoring, however, we find ourselves, and our dedication to our patients, getting lost.

My medical school class, the class of 2010, was the first subject to a revised curriculum. Our first year began with a new class entitled “Introduction to the Profession.” For 2 weeks, we read about cultural misunderstandings between patients and physicians; we discussed the impact of economic and social factors on patients’ health; and we wrote letters to ourselves detailing our fears and uncertainties, our dreams and aspirations. It was, for lack of a better phrase, a “touchy-feely” foray into the field, in which the power and beauty of the patient–doctor interaction featured prominently. We drank it all in. As each session ended and we gathered our bags and empty coffee cups, the room swelled with our collective hope and promise.

Those 2 weeks now blur together. There is really only one moment—or one story—that has stayed with me. During a lecture, Dr. Graham, an internist, told us about an interaction she had with an attending physician on her pediatrics clerkship. One evening, she and this doctor were walking to see a new admission, when the attending took a detour and turned into another patient’s room. The patient’s parents sat by the window. The woman rose from her chair when the door opened, crossed the room, and hugged the attending. A young child lay in the hospital bed, obviously dying. The room was silent but for her labored, rattled breathing. Still embracing the doctor, the child’s mother told him how she had never thought that the child’s death would be this way. She had imagined her at peace, lying in a field filled with flowers at the end, not attached to monitors in an ICU.

For Dr. Graham, this moment defined what made a physician truly outstanding. Her attending had not had any “clinical” reason to see the girl. He had no test results to share and no treatment to render. He had another patient waiting to be admitted. Other physicians might have walked by the room, telling themselves there was nothing they could do. But this doctor saw that he could still care for this family, though he could not save their daughter. He took a moment to comfort her parents and to be present with them and bear witness to their suffering. And in this moment, he made a difference to this family. In her closing remarks, Dr. Graham entreated us all to be doctors who make the detour.

Throughout the first and second years of medical school, our “Patient-Doctor” course (“PD”) carried forth the spirit of “Introduction to the Profession.” One afternoon a week, we trekked over to an affiliated teaching hospital to interview patients. The first year, we learned the medical interview; the second, we learned the physical exam. The sessions were thorough and our contact with faculty extensive. We also had an almost limitless amount of time with patients. For each session, we were given an assignment, such as “characterize the chief complaint.” But our actual task was to sit with each patient and elicit his or her story. I loved this class. I was deeply moved by one moment—or one story—that has stayed with me. After such an introduction, the wards were a shock. Taking care of patients was nothing like interviewing them for PD. There was endless work to be done; the patients were so sick; and the H&P I’d been taught took an hour and a half. I felt stupid, slow, inadequate. I could barely make the requisite stops; making a detour seemed out of