BECOMING A PHYSICIAN

MSL — Medicine as a Second Language

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We were practicing in the nurses' room, with a few minutes to go before the big performance. My classmate Julie and I ran through our lines and critiqued each other. "You have the history and differential diagnosis down," she said, "but you look half asleep. Sit up straight, for goodness' sake." I nodded, trying to remember yet another thing. Then I gave her some advice: "Keep your enthusiasm," I suggested, "but trim the 'normocephalic, atraumatic' bit and the other overly detailed physical exam findings."

Curtain time. Costumed in our short white coats, we entered the conference room from stage right and delivered our oral presentations. I took a deep breath and went first: "Ms. C is a 55-year-old African-American woman with a history of COPD who presents with shortness of breath for one day. . . ."

These seven minutes in the spotlight are the culmination of everything that a medical student does for the medical team: elicit the history, perform a physical exam, gather laboratory results, and synthesize all the data into an argument — a therapeutic proposal. No matter how much compassion and warmth I may have with patients, my superiors grade me more on how polished I am, how well crafted my presentation is. These moments are "your chance to shine," my attendings tell me.

That morning, my posture was good, and my assessment and plan were sound. My attending thought my presentation solid, especially since I kept to his time limit. Julie gave me the thumbs up. But over the course of this year, I've had my rockier moments. Being a premed never prepared me for public speaking. I mastered the Henderson–Hasselbach equation and the physics of laminar flow, but in hindsight, I wish I had also joined Toastmasters.

Of course, the oral presentation is much more than an exercise in public speaking. It is a first attempt to speak the language of medicine. In one respect, the classroom years were a massive vocabulary lesson in "medicalese." By the end, I was cramming in as many minutiae as possible — what are the rickettsial diseases? the classic triad of Sjogren's? — to take the big quiz, Step 1 of the U.S. Medical Licensing Examination. Legend has it that after medical school, a newly minted doctor has some 55,000 new words in the memory bank.

Entering the wards during the third year, I was surrounded by fluent speakers. There was no choice but to begin speaking the mother tongue. Despite my new vocabulary, I was lost at first. Speaking English and throwing in a fancy medical term here and there doesn't cut it. Medicine has its own rules of grammar and style, best learned through oral presentations. The full patient history and physical (H&P), the consult call, the morning-rounds card flip — each provides a framework that enables doctors to communicate in their own language.

Early on, I learned rule one: heed syntax. As one professor put it, "Never order dessert before the salad." In other words, in any presentation, adhere to the chronology that your listeners expect. Hospital training wires physicians to think in the structure and rhythm of the H&P. One swap made, and a student confuses the team. For example, if I give the patient's sodium level before the vital signs, the residents will be wondering, "What was the temperature? Is he hypotensive? I wonder why she gave the labs before the vitals. . . ." And by then I've lost my audience.

As in many languages, doctors conjugate — not their verbs, but their ideas, rendering the formal or the informal depending on the listener and the situation. I learned from a kind second-year resident that I can't give the full-blown seven-minute H&P to a consult; it would be, to put it lightly, inappropriate.

"Let's practice the one-liner, Rachel," she offered. Practice, I thought? Why do I need to practice *one* sentence? I'd soon find out that the infectious-disease fellow who answers the consult call is harried and wants all the details jam-packed into one breath, and if I stutter or hesitate, she'll start zoning out or she'll sigh and make me even more nervous and uncommunicative.

The beauty of the one-liner is the time-saving fac-

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tor, which is fundamental to all medical discussion: be succinct. That's the medical version of rule 17 in Strunk and White's *Elements of Style:* "Omit needless words." I struggle to identify which details to drop. When I wrote for a news magazine before medical school, I often had to shrink hours of interviews into short stories. A phrase lost here or a quote cut there was disappointing. But in medicine, if I edit out a relevant finding of the history or exam, I worry about compromising the patient's treatment.

"Just give me pertinents," a resident told me recently before a presentation to the neurology team. But which physical findings in my 75-year-old patient with gait instability did she want? Only the ones that had changed since the patient's admission? All the positive findings, even if they hadn't changed? What exactly did she mean by "pertinent"?

Moreover, each resident or attending has his or her own style. How nit-picky is she? Will she want to know whether he had a bowel movement last night? Or how he slept? Like many medical students, I tend to err on the side of inclusion. Maybe I'll get a few yawns, but I'd rather give extra details than omit something vital.

Learning medicine as a second language can be trying, and not only because fluency varies tremendously with the team — or "host family" — to which I'm assigned on a given rotation. It is also trying because, before I can even become proficient in this language, I am charged with the task of translation. Indeed, I must constantly navigate two worlds, patient-speak and doctor-speak, and hardly do the two meet.

Oddly enough, patients don't give a concise History of Present Illness, then proceed to their Past Medical History, quickly adding their Medications/Allergies and Health-Related Behaviors. Oh, but I wish they would. Instead, patients' thoughts meander as they tell their stories. (I might have called their thinking "circumstantial" or "tangential" when I was on my psychiatry rotation.) How, then, to justly distill their world of suffering into a seven-minute presentation?

That struggle should get easier with experience. For now, my preoccupation with learning to communicate appears to be a growing pain common to many medical students. A few years ago, Lorelei Lingard, a rhetorician from the University of Toronto, spent several weeks on call with medical teams at San Francisco General Hospital, observing how students acquire their oral presentation skills.[1] Lingard and her coauthor, Richard Haber of the University of California, San Francisco, concluded that students viewed and conducted their presentations in a rigid fashion. Even after receiving feedback suggesting changes, students held fast to their practiced presentations. Residents, by contrast, improvised according to context. These more seasoned trainees saw the presentation as a flexible means of communication.

This difference in perception and practice makes sense. First-timers need structure and thus sound stilted. Seasoned speakers have internalized the rules so that their language comes off more naturally. As one student observed, the experts can "play jazz" with their presentations. Students indeed strive to be nimble, but as novices, they don't know yet which rules to bend. The saxophone squeaks when it should sing.

Fluency always takes time. With more experience, the oral presentation will no longer feel like a sweaty-palm performance. It will no longer feel like a structured exercise in data collection, with an exhaustive list of blanks to fill in and a write-up as cue card. Presenting, in time, will become the beginning of a beautiful conversation.

1. Haber RJ, Lingard LA. Learning oral presentation skills: a rhetorical analysis with pedagogical and professional implications. J Gen Intern Med 2001;16:308-14.