Doctors are People, Too

The young people around the two tables, almost all of them wearing gray and black suits, look a lot more alert than most people do at seven in the morning. There are about 15 of them, mostly in their early twenties. They're being told that they're about to go into a situation for which they could do nothing to prepare, something this group is not used to hearing, and does not like to hear. They are pre-med students. They've made it through two rounds of applications already. They're about to be interviewed for admission to the medical school at University of California, Davis.

"It's somewhere between speed dating and being on a game show," Francis Sousa, an ophthalmologist and the dean of faculty at the school, has already told the group. "So it's kind of fun."

The would-be students do not look convinced. Some of them have probably spent four years of college, maybe more, preparing for an intense interview with one to four people in which they talk about themselves and why they want to be doctors. This is not that. Instead, they will be herded through a sequence of ten rooms, each with a different surprise scenario that observers will watch as the candidates try to perform and display their interpersonal skills. In some rooms students might be presented with a puzzle, or a problem to solve with another applicant. Some involve role-playing a tricky situation with a hired actor. For example: A friend of yours has heard about a controversial and untested health treatment that they want to try, and you believe it could be dangerous. How do you talk to your friend about this? Some stations offer applicants a more traditional opportunity to talk about themselves and why they want to go into medicine.
It's called the "multiple mini interview" process, or MMI. It has become widespread at Canadian medical schools, and is creeping into the US schools. Its proponents will tell you it represents the best new way to judge personal qualities, and that it's only going to get bigger and bigger.

The MMI only works if the process adheres to a strict time schedule and everyone switches rooms promptly. Each scenario takes a total of ten minutes - two minutes to read the scenario outside the room, and eight minutes to carry it out.

"Is there a clock in the room?" asks a young male applicant in a dark suit and red tie.

"I hate clocks in rooms," Sousa says. "Well, there may be a clock in the room. But is it working? No."

He tells the applicants that they will receive a one-minute warning before the time at that station is up, and that the two minutes they have at the beginning to read the scenario will probably be more than enough. Most of them do not look reassured.

The traditional medical school interview is similar to a job interview, or an interview for undergraduate college. Usually there are two one-on-one interviews, a half hour to 45 minutes each, with faculty members, fourth-year medical students, or school administrators. Before sitting down, the interviewer has reviewed the applicant's file and picked out the conversation starters and jumping-off points. ("Tell me more about studying abroad in Ghana." Or: “What was it like to shadow a urologist?”) The candidate has ample time to expand and nudge the conversation toward topics that might present the most flattering possible picture.

But advocates of the MMI say those old-fashioned interviews end up pulling too much of the wrong information. At schools where the new rapid-fire testing exercise is underway, admissions officers say they are receiving a better, less biased measure of their
candidates' interpersonal skills. The process involves more raters, so anyone who has a rough time at one station still has a shot at redemption during the others. The process is also blind — the raters don’t see the interviewee’s paper application or know anything about the applicant, and don’t see each other’s ratings.

It can be a difficult sell for applicants who have been told for years that they are the sum of their experiences and qualifications. They are used to presenting themselves, not being observed. And it’s simply not the way we humans are used to getting to know each other — no one would ask a potential love interest to perform household duties or interact with children before sitting down and having a conversation.

"I changed people so often," says Jennifer Chin, a U.C. Berkeley senior who in 2010 became one of the new medical school applicants to be assessed in this unusual way. "I felt like they didn’t have a sense of me."

By last December, when her experience as a modern medical school applicant was finally nearing an end, Jennifer had applied not only to Virginia Tech, where she endured her MMI experience, but also to 26 other medical schools. She's a 22 year-old Chinese-American woman, with lots of friends and extracurricular activities, and her big ideas about being a doctor don't necessarily involve making a lot of money. Her grades are good but not the best. She likes to keep a balance in her life. She may be just what medical schools are looking for - smart and capable, with a strong sense of purpose and good interpersonal skills.

So how should medical education assess a young woman like Jennifer? What is the best way to figure out if she really means what she says about caring for people and liking children? And although she says she believes communication skills and working cooperatively are important qualities, does she actually possess those qualities? Is she good at what she thinks she’s good at, and does she care as much as she says she does? Questions like these, about how to measure a person’s humanity, are helping drive the medical community to look for better screening tools — and to think generally
about how medical education can put more emphasis on cultivating future doctors’ softer sides.

“Everything I’ve done so far, I knew that if I worked hard, something would come out of it,” Jennifer says. “With applications, you can work really hard and nothing will come out of it.”

Fewer than half of all medical school applicants in the United States get in — to any medical school, not just the program they most wanted. The nationwide average is about 14 applications per person. Jennifer knows someone who applied this past year to 50 schools. Applicants who don't make it in face tough choices: they could apply to non-U.S. schools without solid reputations (schools in the Caribbean catering to these students have become popular); apply again, which is costly; or pursue another field entirely, potentially making a big chunk of what they spent their undergraduate time on feel like a waste.

As with most admissions processes, deciding which group makes it is complex and imprecise, something many doctors dislike. The people pushing the MMI believe the system goes part of the way towards minimizing that ambiguity.

In the last few years, at least a half-dozen American schools have adopted the MMI process. Fourteen of the 17 medical schools in Canada, where it started, now use the MMI to screen candidates for personal skills. It’s a notable ripple in an atmosphere where numbers — grade point averages and Medical College Admission Test (MCAT) scores — have typically carried a lot of weight. In any undergraduate school in the country you are likely to find first-year students already stressing about how many science classes to take and whether their grades will be good enough for medical school.

But in late 2009, the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC), two of the most influential medical organizations in
the country, joined for a conference on changing medical education. Topping their
priorities list was a mandate to figure out better ways of assessing “behavioral
competencies,” — those personal qualities that don’t show up in grades and test scores.
Altruism, professionalism and resilience, for example, are qualities the traditional MCAT
can’t seem to predict for. The MCAT does do a good job of predicting for academic
performance in medical school, and it’s a result of decades of development and
tweaking. But admissions officers also say there's room for improvement in assessing
certain personal skills, and that these skills affect a doctor’s ability to provide care
effectively. Because it’s not really about finding people who will be good at medical
school, it’s about finding people who will be good at practicing medicine.

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Health care is one of the fastest-growing fields in the country, according to the Bureau
of Labor Statistics, yet there are serious doctor shortages predicted for the next few
decades — in primary care, rural care, and specialties in rural areas. While Jennifer
wants to become a pediatrician, many of her colleagues will vie for competitive specialty
areas that promise more money and more agreeable schedules. Medical schools have
the challenge of looking for people who are not only competent enough to survive the
rigorous training it takes to become a doctor, but who will be able to weather the storm
of future health care challenges and guide the industry in the right direction.

Before 1910, medical education in the United States was a kind of Wild West
commercial enterprise. Most schools were for-profit institutions that had more in
common with trade schools than today’s medical schools. Curricula varied widely.
Schools were able to keep costs down by not providing expensive aspects of medical
education, such as laboratories, so tuition was cheap and many programs were only a
year or two long. Admission was open to anyone, and there were no licensing exams or
standardized procedures to determine someone’s right to practice medicine. As a result,
it was easy to find a doctor — the country was saturated with them. But it was hard to find health care that wasn’t shoddy.

The commonly accepted narrative in medicine is that a man named Abraham Flexner helped changed all that. He was commissioned by the Carnegie Foundation to perform an audit of medical education in the US and Canada, and he was dissatisfied with what he found. His resulting report, *Medical Education in the United States and Canada*, published in 1910, set into motion huge changes for medical education, and many existing schools shut down. According to Flexner, 457 medical schools were founded over the course of a century, although many of those didn’t last long, and some never even got off the ground. At the time of his report, there were 155 in the US and Canada; today there are 134 in the US, and 17 in Canada, for a much larger population. He urged the nation’s medical colleges to produce fewer but better trained doctors, and eventually the result was what he had hoped for: a higher standard of medicine, and a decrease in doctors.

Jennifer in part has him to thank for the four-month period when she spent 27 hours a week studying for the MCATs. After medical schools started becoming more rigorous, dropout rates soared. Educators decided that tightening admissions procedures and creating a standardized test might alleviate the problem, and the first Moss Test, the MCAT’s ancestor, was created in 1928. Twenty years later the Moss became the MCAT — the Medical College Admissions Test. The current MCAT is a grueling five-hour test with four sections: physical sciences, biological sciences, verbal reasoning and a writing sample.

For Jennifer, the MCAT represents the most focused and structured studying she’s ever done. She took a Princeton Review class to prepare, during the spring semester of her junior year at Berkeley, and created a strict study schedule for herself to ensure that she wouldn’t neglect MCAT studying for her coursework. She spent three hours each weekday on test preparation, usually in the apartment she shared with two friends about a half-mile from the Berkeley campus, on the couch, hunched over a plain wooden desk.
found on the street, eating baked goods or dried mango. On weekends, she’d walk over to the test prep center for her class, which took up six hours each Saturday and six hours each Sunday. That routine went on for four months.

“I was taking the test on a Saturday, and on the Wednesday before, I got the lowest score I’d ever gotten on a practice test, so my friends told me to stop taking practice tests.” she says. “I felt like it was going to determine my future.”

Jennifer is a public health major. Her simple and casual outward appearance — she doesn’t wear makeup or flashy jewelry, and her clothes are presentable, but practical and comfortable — matches her demeanor. What you see is what you get, and what you get is sincere and capable. She smiles easily, but not excessively, and when she talks, she seems to say exactly what she’s thinking, but no more or less, and without judgment. She believes a good doctor should be able to relate to people well on a mental and emotional level, and feel a sense of responsibility for her patients. One of the doctors she’s shadowed, a pediatrician in Berkeley, taught her what it means to go the extra mile for patients: he stays at work after hours doing research on their illnesses, calls specialists, and takes their late-night phone calls. That’s the kind of doctor she wants to be.

After a trip to Honduras with a campus group where she went into impoverished communities to provide medical care, she became especially interested in global health issues and working with children.

She grew up in a Seattle suburb, the daughter of a Microsoft software engineer and a pharmacist. Although she knows she won’t make as much money as a specialist, she wants to be a pediatrician. For her, pediatrics seems like it would be the most intellectually stimulating area of medicine, and would also satisfy her desire to work with people and fill an important need.
By most measures, Jennifer is an exemplary student and contributor to her community. Her commitment to health is clear and her grades and MCAT score, while not in the top percentiles, are solidly within the range of scores for accepted applicants. But she’s also somewhat typical of her fellow medical school applicants — which is why the jobs of the admissions officers determining her future are particularly hard.

Dr. Harold Reiter, the chair of admissions at the Michael G. DeGroote School of Medicine at McMaster University, in Hamilton, Ontario, has taken the lead in trying to find better ways of making the Jennifers stand out in the pool of applicants. The MCAT and academic grades tell a great deal about certain qualities, Reiter says — "there are very few dumb doctors out there," he observes. But he claims they fall short on other important qualities, such as a sense of ethics and ability to empathize. "The common methods that have tended to be used for attempts at measuring personal characteristics have largely failed," Reiter says.

Reiter is one of the architects of the Multiple Mini Interview. He was on the McMaster medical school admissions committee in 2001, during a time of staff turnover. The Health Sciences school, of which the medical school is a part, had a new dean whose slogan was “revolution, not evolution.” Reiter was tasked with looking into the admissions process and finding ways to improve.

The traditional interview, the personal essay, and letters of recommendation turn out to be the least reliable parts of any medical school application, Reiter and his research colleagues believe, if the point is to sift really good potential doctors from mediocre ones. They give too much "control of assessment," as Reiter describes it, to a candidate so anxious to be admitted that he or she is willing to fudge a little bit. It's not that asking candidates questions about themselves can't be worthwhile. That's the way most people get hired, in a variety of fields. But the medical school applicants are already a highly select group. They tend to be more similar to each other than many other groups, such as applicants to undergraduate colleges or those applying for a job opening with a public listing. The tighter a pool of applicants is clustered, the more difficult it is to
distinguish reliably between them, and the greater the need for more precise
assessment tools. Medical admissions officers also talk about the “halo effect” — a bias
interviewers may have because of all the glowing qualifications listed in the applicant’s
file, or the reputation of the school they went to — of applicants before the interview
conversation even begins.

As Reiter worked to find a system that might improve the interview process, it occurred
to him to try using some of the principles employed by a type of exam already being
used for medical students, the Objective Structured Clinical Exam. The test pushes
students through 10 different stations, each set up with an actor presenting a set of
symptoms the medical student must diagnose on the spot. The concept seemed
promising as an admissions review process, too, and Reiter proposed it to the rest of
the committee. The test relied on observing students in almost-real-life situations rather
than self-reporting, so he guessed it might provide more reliable information than the
traditional interview.

He could also design the test so that the raters would never see the rest of an
applicant’s application — so, no halo effect.

“The argument was that we knew the standard interview predicted for nothing,” says
Reiter. “We could do no worse.”

The school launched a pilot test later that year, and studied the process until 2004,
when it was implemented for all applicants.

McMaster still includes some stations in their MMI that ask more traditional questions -
“why do you want to be a doctor?” for example. But those are more to make the
applicant feel comfortable and listened to, Reiter says, than to contribute to valuable
admissions data.
The MMI has skeptics. David Neumeyer, dean of admissions for Tufts School of Medicine in Boston, remains a fan of the traditional sit-down interview. “The purpose of an interview is to verify certain things about an applicant's qualifications and assess their ability to communicate,” he says. “And I don't know a better way of doing that than just sitting down and talking to somebody.”

The MMI is too impersonal, he argues, and he says he's not convinced it does a better job. “Certainly there are people who can put on a good face for two half hour interviews and fool us,” he says. “And I'm sure those same people can put on a good face for the MMI and fool the group.”

And at the University of Cincinnati, which in 2007 became the first American medical school to adopt the MMI, assistant medical school dean of admissions Stephen Manuel says there are still a few holdouts on the admissions committee. “They don't think it works,” says Manuel. “They have absolutely no research. But they are convinced that the quote, unquote, old way of doing it is the best way of doing it. And like evidence-based medicine, you can show people all the data in the world but they're not going to change the way they're doing things.”

Some schools also may be resisting simply because of resources. They might not have rooms that work for the MMI, or enough people to serve as raters and interviewers on the same day. Implementing a new process can be daunting, and the MMI requires many logistical shifts.

But the MMI is only one piece of a bigger effort on the part of the medical education community to rethink the whole notion of personal characteristics and how personality fits into medicine.
In 1982, a Newsweek article titled “What’s wrong with premeds” caused a ripple in medical circles by describing the era’s pre-med students as one-dimensional grinds, focused on getting into medical school to the exclusion of all other aspects of life, and at the expense of enjoying the learning process. The article was based on a concerned Harvard Medical Alumni Bulletin report about “pre-med syndrome” in many Harvard students of the time. They were “excessively competitive, cynical, dehumanized, over-specialized and narrow,” the report complained. Competition and high stress levels were reportedly rampant among pre-med students, extracurricular activities almost nonexistent, and grades were of singular importance to the afflicted students.

In 1986, a sociologist at Brandeis University, Peter Conrad, conducted a study of the perception of “cutthroat” students among pre-meds. While he did not find evidence that actual cutthroat students existed in significant numbers, he found that the myth was pervasive, and had real consequences among students. They felt high levels of competitiveness and some students were dissuaded from going into medicine based upon the perceived personality types of their future colleagues.

And some students today say the cut-throat atmosphere is not all myth. Jessamyn Conell-Price, a 26 year-old Bay Area medical student, says she almost didn’t apply to medical school because she feared her fellow classmates would be like pre-meds she’d had classes with as an undergraduate. She loved science, but was discouraged by pre-med students in her science classes who seemed to be taking the joy out of the subject and turning it into a memorization game focused on grades.

It made her worry, she says, about what kind of people her colleagues would be if she did become a doctor. “One of my big concerns was that I felt like doctors weren’t curious and questioning enough,” she says. “I felt like doctors were more about success and being driven. Then I realized that there are doctors who are both ways, and all kinds of ways.”
She eventually decided she did want to apply, and she’s now a first year in the UCSF-Berkeley Joint Medical Program, a slightly alternative program with a focus on teamwork and learning through case solving. She plans to be a primary care physician with a focus on geriatric care.

The Joint Medical Program is designed for doctors like Conell-Price, who want a little more of a well-rounded approach to learning that draws from multiple disciplines and relies on a lot of analysis and questioning. Graduates complete both an M.D. and a Master of Science degree in five years, and learn the medical curriculum in a small close-knit group that requires them to cooperate with each other. They are also encouraged to start working with patients early, and a high percentage of them go into primary care.

Pre-med students don’t talk about patients as much as they talk about their odds of getting into school, but patients are, after all, the whole point. And they are the reason medical educators want to do a better job of training students to be better communicators. Patients don’t necessarily know whether their doctor ordered the right test or assessed the right symptoms to make a diagnosis, but they can judge whether the doctor is communicating with them well. A 1994 study on malpractice suits found that in nearly two-thirds of suits filed, the plaintiffs cited a communication issue on the part of the doctor as one of the factors persuading them to sue. Specific complaints were cited: The doctor didn’t follow up when he or she promised to. Or the doctor appeared to dismiss or underestimate the patient or relatives and didn’t explain things fully. Or the doctors seemed too self-important to spend time with the patient, or generally didn’t make the patient feel taken care of.

In the past, doctors facing potential malpractice suits have been advised by their lawyers never to apologize, lest they admit liability. But doctors and hospitals are rethinking the effectiveness of that policy and apologies are becoming more common. At least 36 states have implemented laws that prevent apologies from being used as admissible evidence in court, allowing doctors to apologize freely. Some hospitals have
specific programs encouraging their doctors to apologize when they make mistakes, and have documented a significant decrease in complaints filed.

These changes have only occurred in the last 20 years or so (Massachusetts was the first state to enact an apology law in 1986), but preliminary studies have shown that the laws could be effective in reducing the amounts of payments, the number of claims filed, the number of cases that go to trial, and the time it takes to reach a settlement. Just by saying “I’m sorry.”

After all, helping people is what doctors do. The vast majority of them care about upholding that commitment, even if they aren’t always good at showing it.

It’s unclear why it’s taken until now for the medical education community to commit to a more human focus. Dr. Henry Sondheimer, director of student affairs and programs at the Association of American Medical Colleges (AAMC), says the organization is committed to finding better ways to assess future physicians' personal characteristics. Sondheimer's organization administers the MCAT, and it is planning, for example, to add to the test a new section that explores candidates' ethics and aptitude in the social sciences. Those changes won’t happen until 2015, and the details of the new section have not yet been released. But the hope is that the new test will encourage candidates to pay more attention to the human side of medicine. Sondheimer also hopes that emphasizing personal qualities in tests and interviews will help identify doctors who can work together better.

“People are not practicing solo medicine, nor should they be — they’re practicing in groups.” Sondheimer says. For example, he describes a pediatric clinic with multiple doctors, physician assistants and nurse practitioners, where patients may see someone different each time they come in. Group atmospheres could be highlighting the need for interpersonal skills and bringing the discussion more to the forefront.
For Jennifer, the prospect of working with people, not just for them, is part of the appeal of pediatrics rather than specialties that demand less human interaction and collaboration, such as pathology or radiology. Plenty of her colleagues also want to be primary care doctors in some capacity, but plenty of them don’t, and the country is facing a severe shortage of doctors in the next few decades. The AAMC Center for Workforce Studies predicts a shortage of between 124,000 and 159,000 physicians by the year 2025. That number includes all kinds of doctors, but experts are particularly concerned about a shortage of primary care physicians.

According to the AMA, in the last 30 years about a third of all doctors have been primary care doctors. The number of doctors going into primary care is falling in recent years, however — between 2002 and 2007, it declined by 27 percent. Add to that a rising population, a big cohort of aging people (baby boomers), and the recent federal health care regulation that could increase the number of insured. The number of people needing health care is set to outpace the optimal proportion of doctors. In Massachusetts, where health insurance requirements have been in place since 2006, there are already reports of people having increased difficulty in finding doctors or getting appointments in a timely manner. Predictably, the problem is worse in rural and under-served areas than in urban ones.

On top of fewer doctors going into primary care and the population outpacing medical training in general, doctors are also working less than they used to. A report in the Journal of the American Medical Association in February 2010 found that in 1998, doctors worked an average of about 55 hours a week, and in 2008 it was down to about 51 hours a week. The report’s authors calculate that the loss in hours equates to about 36,000 physicians being taken out of the workforce.

Medical students have plenty of reasons for wanting to go into the most sought-after specialties. The top four are sometimes referred to by the acronym ROAD - radiology, ophthalmology, anesthesiology, and dermatology. These specialists will almost certainly make more money than primary care doctors, face fewer bureaucratic hassles, and in
many cases, have more control over their schedules. The intellectual challenges these specialties present may also seem more interesting to some medical students, just as the challenges presented by primary care will seem more interesting to others.

Jennifer says she likes the idea of seeing a variety of health issues as a primary care doctor and having to think critically to solve problems. “As a primary care physician, it’s a gateway for everything else,” she says. “They’ll come to you first. It’s really challenging and unique in that sense.”

She’s a little bit worried about paying off her substantial medical school loans - most students finish with about $150,000 in debt - but not so concerned that it would change her decision.

“A primary care physician is not making a bad salary," she says. "I won’t be really poor. I don’t think I need that much money.”

Most medical school applicants don't know what area of medicine they want to go into when they apply, and are not expected to know. Furthermore, many of the ones who do know, or think they know, haven’t experienced any of it, and may change their minds. The rotations medical students go through during the third or fourth year of medical school are meant to help students figure this out. But in the meantime, some schools would like to find people they think are likely to go into primary care, or at least value the principles of public service.

When Jennifer began to put together her list of 27 schools to apply to, she went to the US News and World Report website to see which schools were considered best in clinical care. The rating service produces different ranking lists for medical schools based on a variety of emphases, but the default list people refer to the most and that appears at the top of their website, is based primarily on research. The primary care list is right below it, and certainly students who are looking for a good primary care education in particular will refer to that one, as Jennifer did. But a simple glance at the
top ten of both lists will convey that primary care carries less prestige, or at least less
cognition - University of Washington, University of North Carolina, Oregon Health and
Science University versus Harvard, University of Pennsylvania and Johns Hopkins.

A group of researchers in DC went a step further and compiled rankings, published in
the Annals of Internal Medicine in June 2010, assessing schools on a more thorough
examination of “social mission,” taking into account multiple factors that they believed
contribute to improving community health. The top school? Morehouse School of
Medicine, a historically black school in Georgia that has only had a full medicine
program since 1981. The bottom school? Vanderbilt University, a private school in
Tennessee that has been awarding degrees since 1875. Not all of the bottom 20 are
private schools or big names, and the list is definitely not a direct flip-flop of the
research rankings, but almost all of the top 20 are schools with a community focus that
the general public doesn’t usually hear much about.

Jennifer wasn’t particularly preoccupied with schools rankings or reputations. She even
applied to a number of newer schools where she would be in the first or second class, in
the hopes that it would help her chances of getting in somewhere.

“At a certain point, I feel like all medical schools are good and it's just a matter of which
ones you fit to and which ones your personality fits to best,” Jennifer says.

She’s heard that reputation matters to an extent when applying for residencies, but she
doesn’t believe any accredited school would provide a bad education. Her first choice all
along was the University of Washington - ranked first in clinical care, as well as located
in her hometown of Seattle. She’s very close with her family, and being able to attend
medical school near them would be a big plus.

“The best medical school in the country,” people in medicine like to say, “is the one you
get into.”
Jennifer was recently asked to serve on a panel for a talk given by the Pre-Med Honor Society at Berkeley about applying to medical school. She was asked in part because she was an acquaintance of one of the organizers, but mainly because she interviewed at a number of places and got into multiple schools, an achievement in itself. She was glad to be able to provide some guidance to students just starting the process, where she was a few years ago. Despite the frenzy surrounding the medical school application process, many students don’t necessarily know what they’re getting into from the beginning. She said jaws dropped when she told them how many schools she applied to and how much money her applications, test preparation and interview travel cost her (just over $8,000).

In early April, she learned that she was rejected from her first choice, the University of Washington. But she was admitted into Florida International, Oakland University William Beaumont, the Uniformed Services University Health School (the military’s medical school), Michigan State, and Tulane. She was wait-listed at Case Western, Virginia Commonwealth, and Virginia Tech — that last school is where she went through the MMI. She also turned down interviews at several other schools, once she’d received acceptances at schools where she knew she could be happy.

Jennifer’s final decision: Tulane University, in New Orleans. She loved the city when she visited last fall, and felt that the students there seemed happier and more satisfied with their education than those at some of the other schools she visited. Tulane is a community-oriented school, and she thinks it will be a good fit.

She plans to take a year off before starting school, and work with a Seattle nonprofit that helps low-income patients with the logistics of obtaining and keeping appointments with doctors. While she has shadowed two doctors and worked in other health settings,
she feels that she hasn’t seen medicine from the patients’ perspective as much, and believes her intern year will help her do that.

“I think when I started, I thought it was going to be impersonal,” she says. “That there was nothing else I could do, other than do well on tests.”

Though the MMI is designed to assess personality more accurately, she says the version she went through at Virginia Tech turned out to feel like one of the most impersonal parts of the whole application process. The day started with breakfast at 8 a.m., and she was part of the first group of the day to go through. Though she knew what to do — to change rooms when she heard the bell — she didn’t feel prepared for the types of questions she would get, and it took her a few stations to warm up and get the hang of it.

“I was stumbling a lot on my words and my ideas,” she says, remembering her first few stations. “I had an answer form in my head, but once I started speaking it out loud I would realize it didn’t totally make sense and I would sort of change my idea.”

In one of the stations, she was asked to talk about elderly care, and got a little off track. “I got really emotional about it because I started talking about my grandmother,” she says. “I started panicking then, because when I get emotional it usually doesn’t turn into something coherent.” She had to rein herself in before any of the precious eight minutes at that station slid by.

But some of her nervousness was also due to it being her very first medical school interview. She does see how the method could work, even if it didn’t go down well for her. “I would be interested to see how I would do another time, because I feel like my opinion right now is sort of tainted by the fact that it was my very first.”

Aside from the MMI, the portion of the application she had the hardest time with was her personal statement for all the schools — she left it towards the end, and thinking about
how to explain why she wanted to be a doctor sparked a wave of discouragement and
doubt. “It’s just really difficult to explain why you want to be doing something for the next
8 years of your life in a page,” she says.

She ended up talking about a health scare and surgical procedure her grandmother
had, and how the experience clarified for her the importance of access to good health
care. Seeing her grandmother restored to health made Jennifer want to be able to do
that for others, especially underserved populations.

Jennifer says she knows her work is only just beginning, and that her medical training
will be a long road. But she thinks that when she’s in school, she’ll feel more supported
by the faculty and students around her, and will have more resources and
encouragement to succeed than she did during the application process. Which she
probably will, as long as the Tulane admissions committee was able to determine which
students were the ones who will support and encourage each other.

“I have seen the disparities in healthcare and want to be part of the solution,” she wrote
in her personal statement. “My motivation to succeed in medical school stems from my
belief that becoming a doctor is the best way I can positively impact people’s lives.”
Source List for “Doctors Are People, Too”

By: Natalie F. Jones
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Jennifer Chin, fourth year student, UC Berkeley, Berkeley, CA

Jessamyn Conell-Price, first year student, UCSF-Berkeley Joint Medical Program, Berkeley, CA

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