demic medical centers to query their members on the factors that drive engagement, with national benchmark data available for comparison. This survey can be augmented with school-specific cultural audits. At our institution, a cultural audit revealed important opportunities for improving inclusivity, such as implicit-bias training for mentors and leaders, structures supporting accountability and bystander advocacy in response to microaggressions and discrimination, and the expansion of collegial networks to support advancement.[5] We believe that, taken together, these strategies could substantially move the needle toward diverse representation in medicine.

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None of the Above — The Patient beyond the Multiple Choice

Charlotte Grinberg, M.D.

I lived most of my childhood in the same home as my grandparents. It felt important to be nearby in their later years, so I chose to attend a medical school only a short drive from their home of six decades.

When one day my grandmother tripped over her garden hose and broke her hip, I accompanied her to the emergency department (ED). Although I was only a second-year medical student, I already had more medical knowledge than any other local member of my family.

I held my grandmother's familiar hand as she and the ED doctor talked through the series of events that led to the fall. After obtaining the when, where, and how, the doctor asked, "Do you have any significant family medical history I should know about?"

My grandmother turned up her hearing aid before answering. "My husband passed away a few months ago," she said.

Without hesitation, the doctor responded, "Well, that is totally irrelevant." He walked out of the room, saying he'd come back soon, which in reality meant hours later.

My grandmother, who never had trouble speaking her mind, turned to me and said, "I don't like that man very much."

In those 2 years of preclinical courses in medical school, before entering the hospital to care for patients, I read and answered tens of thousands of patient-vignette questions. "A patient presents after a motor vehicle accident unable to breathe spontaneously." "A patient presents with active bleeding. On exam, her cervix is open and her vagina contains fetal tissue." "A child is brought to the emergency department for evaluation of recurrent injuries. She has had multiple rib fractures and there is bleeding inside both her eyes." The only goal in reading these vignettes was to choose the correct answer. The right answer meant a better test score, which meant matching at a better residency program. It did not cross my mind to consider how I would speak compassionately with the family of the patient in the car accident, empathize with the woman having a miscarriage, or advocate for the child who might be abused. Instead, I became programmed to identify the medically pertinent information and ignore the other details.

What that ED doctor meant, of course, was that my grandmother and grandfather were not related by blood, so his medical problems were not part of her family history. So yes, if you were

answering a multiple-choice question, that information could be ignored. But my grandmother's answer actually contained a vital piece of information: she had been a caregiver for many years, and the burdens of caregiving had a tremendous impact on her physical and mental health. It's not uncommon for spouses caring for their partners to ignore their own disease symptoms, miss medical appointments, and develop serious health problems, including sleep deprivation, chronic pain, prolonged stress, and severe depression. Screening for and addressing these symptoms should have been part of the process of determining the root cause of my grandmother's fall and preventing future fractures.

In my experience, reading all those clinical multiple-choice questions day in and day out also created and reinforced stereotypes. In some lucky cases, you didn't even need to read the entire paragraph. You saw the keyword and immediately knew the test answer. An easy point. Immigrants have a disease that can be prevented with a vaccine. Businessmen and lawyers who travel have sexually transmitted infections. Nurses and pharmacists have factitious disorders (they deliberately produce or fake symptoms). People experiencing homelessness present with complications of alcoholism or intravenous drug use. Football players and weight lifters are using anabolic steroids. These associations further programmed me to see patients as one-dimensional. They reinforced the false and simplistic belief that the rest of a person's narrative doesn't matter — there is only one answer, no nuance or exceptions, no ambiguity in people's medical histories.

To their credit, medical schools have made sincere efforts to humanize the preclinical years by inviting patients to visit the classroom to describe their experiences to students. I remember a visit from a patient living with sickle cell disease, which can present with episodes of severe pain due to the blockage of blood vessels. She described being frequently labeled and treated by ED doctors as "drug seeking." This perception made her less likely to interact with the health care system, because she felt as if her disease was not being taken seriously.

Consumed with cramming facts into their heads, however, most students in my class spent these patient visits with their eyes glued to exam study guides, or even snuck out of the lecture hall to go study elsewhere. Listening to the actual, complex experiences of patients could wait. Our medical humanities courses were nowhere near as rigorously taught or graded as our other courses, which exacerbated students' beliefs that the psychosocial aspects of medicine are less valued and less relevant than the biologic aspects.

Real patients like my grandmother cannot be easily reduced to stereotypes or five-sentence clinical vignettes. Transitioning from student to practitioner requires a shift in mindset: to see a patient as a person, not a paragraph; to see the right answer as layered and complex, not a single choice. If we can teach the next generation of doctors to navigate that transition gracefully, we will humanize our patients and help them attain better outcomes.

My grandmother went on to have another fall and break her other hip. I wonder whether a repeat could have been prevented if more time had been spent on her story and the root causes of her first fall. And if we had truly listened to her, my grandmother could have let us know that all the care and love she provided to her dying husband was not irrelevant at all.

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