Training Mentors of Clinical and Translational Research Scholars: A Randomized Controlled Trial

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Abstract

Purpose
To determine whether a structured mentoring curriculum improves research mentoring skills.

Method
The authors conducted a randomized controlled trial (RCT) at 16 academic health centers (June 2010 to July 2011). Faculty mentors of trainees who were conducting clinical/translational research ≥50% of the time were eligible. The intervention was an eight-hour, case-based curriculum focused on six mentoring competencies. The primary outcome was the change in mentors' self-reported pretest to posttest composite scores on the Mentoring Competency Assessment (MCA). Secondary outcomes included changes in the following: mentors’ awareness as measured by their self-reported retrospective change in MCA scores, mentees’ ratings of their mentors’ competency as measured by MCA scores, and mentoring behaviors as reported by mentors and their mentees.

Results
A total of 283 mentor–mentee pairs were enrolled: 144 mentors were randomized to the intervention; 139 to the control condition. Self-reported pre-posttest change in MCA composite scores was higher for mentors in the intervention group compared with controls (P< .001).

Conclusions
This RCT demonstrates that a competency-based research mentor training program can improve mentors’ skills.

Editors’ Note: A commentary by J.F. Steiner appears on pages 702–704.

Effective mentoring is critical to the success of early-career investigators. Strong mentorship has been linked to enhanced mentee productivity, self-efficacy, and career satisfaction.1–11 Yet, despite its importance, mentoring is typically learned by example, trial and error, and peer observation.12,13 Given this approach, mentor capabilities are highly variable. Current mentor development and training contrasts sharply with the contemporary rigor of instruction and assessment characteristic of competency-based and practice-centered health sciences education. Encouraging progress toward more formal mentor training is evident at several academic health centers (AHCs),14–17 yet its general merits have been questioned in the absence of experimental evidence to support its value.

We hypothesized that a systematic, formal training strategy would result in significantly improved mentoring competency. To test this hypothesis, we adapted and implemented a published mentoring curriculum18,19 for health sciences researchers.20,21 We conducted a randomized controlled trial (RCT) with mentors of clinical and translational researchers at 16 academic sites to test the curriculum’s ability to improve self-reported mentoring skills across six core competencies, and to examine its influence on mentoring behaviors.

Method
Study sites and population
We conducted this study at 16 institutions in the United States and Puerto Rico (see Acknowledgments for full listing), 15 of which have National Institutes of Health Clinical and Translational Science Awards (CTSAs). Prior to the study, sites had mentoring programs of variable size, focus, and structure. For example, 12 participating institutions (75%) provided orientation for mentors, 10 (63%) formally evaluated mentors, 8 (50%) assisted with mentor selection, 7 (44%) used mentor contracts, 6 (38%) had formal mentor training in place, and 5 (31%) provided financial incentives for mentors.

Eligible participants were faculty currently mentoring trainees who were conducting clinical and/or translational research at least 50% of the time. Recruitment targeted mentors of CTSA.
KL2 scholars, others with K or similar career development awards, and junior faculty, and secondarily mentors of postdoctoral fellows and graduate students. A total of 283 pairs were recruited from a convenience sample of the 1,261 mentors contacted. No incentives were offered. The institutional review boards of the participating AHCs reviewed the study protocol and determined it to be either exempt (n = 11) or approved via expedited review (n = 5).

**Study design**

The trial, conducted between June 2010 and July 2011, employed a mixed-methods approach through which mentoring skills were measured quantitatively and mentoring practices described qualitatively. Following the baseline interviews (see below), we randomized 283 mentors into either the intervention group or the control group, with block randomization by study site (12–27 pairs/site). Mentors and mentees alike completed a 15- to 30-minute pre-test interview three months after intervention (n = 13),21 others offered two 3-hour sessions (n = 1). The sessions occurred over a period ranging from 2 days to 11 weeks; the average was 5 weeks.

**Outcome measures**

Though the study’s curriculum was adapted from Entering Mentoring, the evaluative measures originally used for that curriculum were not applicable to our study population, and we determined that other existent measures were inadequately aligned with the intervention. Therefore, the primary outcome measure was based on mentors’ self-reported scores on the validated Mentoring Competency Assessment (MCA). This 26-item research mentoring skills inventory was designed to align with the six competencies of the curriculum. Mentors rated their mentoring skill levels on a seven-point Likert-type scale (1 = not at all skilled, 4 = moderately skilled, 7 = extremely skilled), rating their own skills globally as they pertained to all their active mentees. Mentees also completed the MCA but rated only the mentor enrolled in the trial; in addition to choices on the seven-point scale, mentees could choose 0 for “not observed” when rating mentoring skills.

We administered the MCA at baseline (pretest) and post intervention (posttest) to all enrolled mentors and mentees. The a priori primary outcome of the trial was the change in mentors’ MCA composite score between these two time points.

The posttest version of the MCA also included a “retrospective pretest” that asked respondents (mentors and mentees alike) to reconsider and re-rate mentors’ baseline skills; mentors and mentees were asked, first, to re-rate mentors’ skills at the onset of the study period (designated as “before”) and then to rate them at the present time (designated as “now”) for each MCA item. This established approach captures changes in the respondents’ perceptions over the study period.23,24

Secondary prespecified outcomes included the following:

1. change in mentors’ awareness of their skills as measured by the change in their self-report composite scores from retrospective pretest to posttest;
2. change in mentors’ self-report subscores for each competency (pre- to posttest and retrospective pre- to posttest);
3. change in mentors’ self-report scores on each of the 26 MCA items (pre- to posttest and retrospective pre- to posttest);
4. change in mentees’ composite assessment of their mentors’ skills (pre- to posttest and retrospective pre- to posttest); and
5. change in mentors’ behavior, as reported qualitatively by mentors and their mentees.

The posttest structured interview for both mentors and mentees included a series of open-ended questions about changes in perceptions and practices since the baseline interview. Please see Supplemental Digital Chart 1 (http://links.lww.com/ACADMED/A192). The interviewers asked mentors and mentees to reflect on whether their understanding of effective mentoring had changed, and to report changes in mentors’ behavior for each of the six mentoring
competencies. For example, interviewers asked mentors if they had changed the way they communicate with mentees, and they asked mentees if they noted any changes in their mentors’ communication with them. We applied content analysis to develop a codebook scheme.25

We coded mentor responses as follows: no change, awareness, intent to change, or implemented change.26,27 We assigned no change, awareness, intent to change, or negative change. To be defined as “positive,” mentees had to describe definitive improvement since the baseline interview; this could be articulated as either a general or specific change in mentoring behavior. We categorized responses as “neutral” when mentees described both positive and negative changes, or when the mentee’s opinion was uncertain. The full qualitative section for each respondent was the unit of analysis and was assigned to a mutually exclusive category; in other words, we did not split any mentee responses into two categories (e.g., both “negative” and “neutral”). Two UW researchers (S.C.H., K.C.S.) independently coded each interview, with intrarater reliability of 98.7% for mentor data and 97.1% for mentees.

Statistical analysis
We summarized baseline mentor and mentee characteristics. We collected data on some of these characteristics, such as research focus, during the posttest assessment, as noted in the results and tables. The prespecified primary analysis was a test for a collective difference between the intervention and control groups in the change from pretest to posttest (self-reported) MCA composite score using the Wilcoxon rank-sum test. We summarized the magnitude of the intervention’s effect on composite score by calculating the mean group difference in pre- to posttest change with a 95% confidence interval. All analyses were intention to treat, so they included all participants completing the posttest, regardless of intervention adherence.

We also analyzed the prespecified secondary outcomes using mean group differences with 95% confidence intervals. For MCA composite score and subscales, mean scores with 95% confidence intervals were calculated for the pretest, retrospective pretest, and posttest assessments. We tested for differences between groups in the pre- to posttest change and retrospective pre- to posttest change using Wilcoxon rank-sum tests without adjustment for multiple tests.

We examined the consistency across sites of the distribution of improvements for mentors in the intervention group composite scores (pre- to posttest and retrospective pre- to posttest), and we used analysis of variance to test for site and site–treatment interaction effects for the primary outcome. We also determined estimates and 95% confidence intervals for the group difference in pre- to posttest composite score by gender and academic rank using a linear model to calculate P values for interaction between treatment group and subgroup.

We used chi-square tests to determine statistical significance of differences in the proportion of changes in mentors’ behavior, as reported qualitatively by mentors and their mentees.

For all statistical tests, we considered a P value ≤ .05 to be significant.

Results
Recruitment and follow-up
We screened a total of 1,261 mentors for eligibility; 283 mentors were randomized and allocated (with their paired mentee) to either the intervention (n = 144) group or the control group (n = 139; Figure 1). Of the 144 mentors in the intervention group, 94% (n = 136) participated in the training, and of these, 82% (n = 111/136) completed all eight hours. For completion of the postintervention interviews, there was a retention rate of 98% (mentors: n = 277; mentees: n = 275).

Characteristics of participants
Mentors’ demographic and academic characteristics at baseline were similar in the two study groups (Table 1). The majority (60%, n = 170) of mentors were male. They had a mean age of 50.5 years (range: 31–81) and were primarily white (91%, n = 257). The majority were full or associate professors and reported extensive mentoring experience (average of 15 years, standard deviation [SD] 8.0 years). Only 21% (n = 59) experienced prior mentor training. The mentors’ research focus areas included laboratory, clinical, behavioral, and community engaged, though the largest percentage conducted clinical research (66%, n = 187).

The baseline characteristics of the paired mentees in the two groups were also comparable. Their mean age was 35.9 years (range: 25–61), and 42% (n = 118) were male. Whereas the majority of mentees self-identified as white (74%, n = 208), 30% (n = 85) self-selected other racial categories. Most mentees were funded by career development awards or postdoctoral fellowships. They were engaged in the full spectrum of clinical and translational research, and similar to mentors, the majority conducted clinical research (69%, n = 196).

Effects of the intervention
Baseline. Between-group self-report MCA composite scores for mentors were not significantly different at baseline (data not shown).

Primary outcome. The mean change in pretest to posttest MCA composite scores was larger in the intervention group compared with the control group (+0.40 versus +0.18, P < .001; Figure 2).

Mentor secondary outcomes. Likewise, three of the six subscale competency self-report scores—communication (+0.53 versus +0.23, P < .001), expectations (+0.45 versus +0.14, P < .001), and professional development (+0.37 versus +0.16, P = .009)—were also significantly larger for the intervention group (Figure 3A–3F).

For the secondary outcome examining change in retrospective self-report pretest to posttest MCA scores, there was also a significant improvement in composite scores in the intervention group compared with the control group (+0.70 versus +0.20, P < .001; Figure 2), as well as in all six of the subscale competency scores (P < .001; Figure 3A–3F). These reflective gains were greater because mentors in the intervention significantly decreased their assessment of their baseline MCA composite score as compared with the control (P < .001).

The mean changes for the intervention and control groups, as well as the
estimates and 95% confidence intervals for the intervention/control differences in mean change, are given in Supplemental Digital Figure 1, http://links.lww.com/ACADMED/A193, for all MCA self-report scores, including MCA composite scores, subscale scores, and each of the 26 individual items.

**Mentee secondary outcomes.** We also examined the mentees’ assessment of their mentors’ skill (pre- to posttest and retrospective pre- to posttest). Post intervention interviews confirmed that 93% (256/275) of the mentees were blinded to the group allocation of their mentor. MCA composite scores, as measured by mentees, were not significantly different at baseline (data not shown). The mean change in pretest to posttest MCA composite scores (+0.35 versus +0.16, \( P = .003 \); Figure 4). Five subscore ratings assessed by the mentees (retrospective pre- to posttest) were also found to be significant: expectations (+0.48 versus +0.21, \( P = .007 \)); understanding (+0.37 versus +0.16, \( P = .002 \)); independence (+0.33 versus +0.15, \( P = .04 \)); diversity (+0.21 versus +0.07, \( P = .05 \)); and professional development (+0.33 versus +0.18, \( P = .01 \); not shown). There were no significant differences in improvements of retrospective pre- to posttest MCA composite score in the intervention versus control group across mentee gender (\( P = .42 \)) or mentee academic rank (\( P = .67 \)).

**Qualitative results.** In addition to MCA skill gains, intervention group mentors reported a significantly greater degree of change in their awareness of mentoring competencies and need to implement behavioral changes. Qualitative data analysis indicated that 97% (137/141) of intervention group mentors reported an increased awareness, intent to change, or actual behavioral change since the baseline interview, as compared with 53% (72/136) of the control group mentors (\( P < .001 \), Figure 5). The majority (87% [123/141]) reported that they had implemented at least one behavioral change, as compared with 42% (57/136) in the control (\( P < .001 \)). Consistent results were reported by the mentees: 68% (95/140) of mentees whose mentors were in the intervention group reported that they noted at least one positive change in their mentors’ behavior as compared with 42% (57/136) in the control (\( P < .001 \)). Further, 44% (61/140) noted two or more positive changes as compared with 24% (33/135) in the control (\( P = .002 \)).

**Subgroup analysis results.** Improvements in pre- to posttest MCA composite score in the intervention versus control

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**Figure 1** Flow of both mentor and mentee participants through a multi-institutional randomized controlled trial of a formal mentoring curriculum for mentors of mentees working in clinical and translational research, 2010–2011.
Research Report

Table 1
Characteristics of Mentors and Mentees in Multi-institutional Randomized Controlled Trial of a Formal Mentoring Curriculum for Mentors of Mentees Working in Clinical and Translational Research, 2010–2011*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mentors</th>
<th>Mentees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention, no. (% of 144)</td>
<td>Control, no. (% of 139)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>93 (64.6)</td>
<td>77 (55.4)</td>
</tr>
<tr>
<td>Female</td>
<td>51 (35.4)</td>
<td>62 (44.6)</td>
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<tr>
<td>Raceb</td>
<td></td>
<td></td>
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<tr>
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<td>135 (93.8)</td>
<td>122 (87.6)</td>
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<tr>
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<td>19 (13.7)</td>
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<tr>
<td>Hispanic/Latino ethnicity</td>
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<td>8 (5.8)</td>
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<tr>
<td>Training categoryc</td>
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<td></td>
</tr>
<tr>
<td>KL2 NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Other K NA</td>
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<tr>
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<tr>
<td>Other NA</td>
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<td>Academic title</td>
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<tr>
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<td>80 (55.6)</td>
<td>81 (58.3)</td>
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<td>17 (12.2)</td>
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<td>49 (35.3)</td>
</tr>
<tr>
<td>Professional degree and PhD NA</td>
<td>53 (36.8)</td>
<td>57 (41.0)</td>
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<tr>
<td>Other NA</td>
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<td>0</td>
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<tr>
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<tr>
<td>Laboratory</td>
<td>67 (47.5)</td>
<td>60 (44.1)</td>
</tr>
<tr>
<td>Clinical</td>
<td>57 (39.8)</td>
<td>51 (36.9)</td>
</tr>
<tr>
<td>Behavioral</td>
<td>57 (39.8)</td>
<td>51 (36.9)</td>
</tr>
<tr>
<td>Community engaged NA NA</td>
<td>22 (15.6)</td>
<td>20 (14.7)</td>
</tr>
<tr>
<td>Experienced prior mentor training</td>
<td>29 (20.1)</td>
<td>30 (21.6)</td>
</tr>
</tbody>
</table>

Abbreviations: NA indicates not applicable; SD, standard deviation.
*None of the between-group P values were ≤.05; percentages are calculated based on the number of participants who responded to each item.
Participants self-reported their race, and some may have self-identified as more than one race.
Training category data were collected post intervention (n = 140 for intervention group and n = 135 for control group).
Participants may have reported more than one research focus, and research focus data were collected post intervention (n = 141 for intervention, n = 136 for control).

Discussion and Conclusions
Our study aimed to address the impact of a competency-based mentor training curriculum designed for the mentors of junior investigators embarking on clinical and translational research careers. To our knowledge, this is the first multisite RCT to provide evidence of perceived skill gains from research mentor training based on reports from both mentors and their mentees.

groups were observed across gender and mentor academic title; see Supplemental Digital Figure 2, http://links.lww.com/ACADMED/A194. We observed consistent improvements in the intervention group MCA composite self-report scores for each of the 16 sites; see Supplemental Digital Figure 3, http://links.lww.com/ACADMED/A195. There was no evidence of a site or site–treatment interaction effect on the primary outcome (P = .73).

Our study aimed to address the impact of a competency-based mentor training curriculum designed for the mentors of junior investigators embarking on clinical and translational research careers. To our knowledge, this is the first multisite RCT to provide evidence of perceived skill gains from research mentor training based on reports from both mentors and their mentees.
We detected a statistically significant difference in the primary outcome variable, pre- to posttest changes in the self-report MCA composite score for mentors in the intervention versus the control group, suggesting improvement in mentoring skills associated with mentor training. Moreover, we observed improvement in three of the six specific competency subscores. When examining retrospective pre- to posttest changes, we observed even larger gains (and significant improvement in all six subscores), reflecting the intervention groups’ reassessment of their baseline skills. Such evidence of reflective learning was also supported by data collected from participating mentors immediately following training.\textsuperscript{21}

We detected skill gains at each of the diverse sites, with intervention-attributable improvements irrespective of gender and career stage, suggesting that the gains are robust. Moreover, we observed control-adjusted gains in nearly every item in the MCA. These measured skill gains are also evidenced by qualitative data that suggest an impact on mentoring practices. The observation that even those with more than 15 years of mentoring experience recognized areas for improvement in their skills and practice suggests that a structured mentor training approach could be a generalizable strategy to improve the quality of clinical and translational research mentoring at academic institutions. We recognize,
however, that mentors who are not self-motivated to enroll in such training may demonstrate different skill gains and behavioral outcomes.

A potential limitation of any measure of self-reported learning is the reliability of respondents to accurately assess their own skills. Mentors in the intervention group who participated in eight hours of training are likely to expect benefits from this experience and may be more inclined to rate their skills higher; however, responses to the posttest interview questions indicate that a greater number of mentors in the intervention group, as compared with the control, reported specific changes in their mentoring behavior, indicating an impact of the training beyond reported skill gains. Furthermore, we are not limited to self-reported data; initial analyses from mentees, who were blinded to their mentors’ group allocation, suggest that mentees of trained mentors perceived changes in their mentors’ competency. These mentees retrospectively reported greater skill gains as well as a greater number of positive changes in their mentors’ practices. These mentees’ observations externally validate the positive impact of mentor training on clinical translational mentoring skills and suggest that a small change in skill assessment may translate to meaningful improvements in mentoring practices. More extensive qualitative data analyses will provide insights into critical factors in mentoring relationships as perceived by both mentors and mentees, as well as the influence of research mentor training.

Although these results are promising, they are limited to short-term outcomes; it is unknown whether they will translate into sustained improvement in mentoring skills. The study timeline further limited the ability to track whether mentor training was associated with enhanced mentee success in terms of grants, publications, and career trajectories. However, this quantitative and qualitative dataset (283 mentor–mentee pairs) may serve as a baseline from which to examine sustained improvements in mentoring skills and behaviors and to track mentee outcomes long-term.

Our RCT findings document the impact of a structured, competency-based research mentor training curriculum to enhance mentoring skills and to stimulate concrete behavioral change. The availability of this evidence-based training program is timely given the national call to train clinical and translational researchers. To facilitate broader implementation, we have published the complete curriculum. This curriculum, as well as adaptations for the mentors of clinical and behavioral researchers, community-engaged researchers, and biomedical researchers, is easily accessible on a new legacy Web site that allows users to download full curricula, build their own curriculum, evaluate their training, and access a range of resources. We hope that providing public access to these training materials and assessment tools will improve career development for health science researchers.

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Please see Supplemental Digital List 1A for acknowledgment of official collaborators/participating investigators, official collaborators/mentor training facilitators, and mentoring.

Figure 4 Comparisons by group of mean Mentoring Competency Assessment composite score assessed by mentees, with changes shown from pretest (“Pre”) to posttest (“Post”) and from retrospective pretest (“Retro-pre”) to posttest (“Post”). Group means with 95% confidence intervals are shown. P values test for group difference in the indicated change.

Figure 5 Self-reported stages of change at the six-month postinterview for the intervention and control groups. Given is the percentage of mentors by group who reported the given stage together with 95% Wilson confidence intervals. The difference in proportion of intervention versus control mentors who reported implementing at least one behavioral change is significant (P < .001).
trial research assistants (http://links.lww.com/ACADMED/A196).

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Other disclosures: W.H. Freeman and Company has published a printed version of Mentor Training for Clinical and Translational Researchers. The curriculum is also freely available for download via a mentoring Web site developed by the UW Institute for Clinical and Translational Research (https://mentoringresources.ictr.wisc.edu). The manuscript was approved by the Clinical and Translational Science Award Program Consortium Publications Committee (https://www.ctsacentral.org/content/cta-consortium-publications) prior to submission for publication.

Ethical approval: This study was reviewed by site institutional review boards and determined to be exempt or approved via expedited review as minimal risk. ClinicalTrials.gov Registry, registration identifier: NCT01184131, http://ClinicalTrials.gov.

Disclaimer: The funding source did not play any role in the design and conduct of the study; in the collection, management, analysis, or interpretation of the data; or in the preparation, review, or approval of the manuscript. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.


References

During a panel designed to humanize mental illness for me and my fellow preclinical students, a round, but well-kempt bearded man unfolded the details of his life with schizophrenia. He spoke of how his illness had led to years of homelessness, and he recounted in vivid detail the small slights over those years that had dehumanized him. While homeless, what hurt him the most was the lack of acknowledgment. Days would pass without anyone saying good morning or looking him in the eyes. Fear pervaded his stories, and, though his demeanor was well controlled, he quivered while reliving those 13 hard years.

After sharing a particularly vicious anecdote, in which he described waking up to several teenagers urinating on him, he relaxed fully, taking in a deep breath and letting it out slowly. Then he told the story of how he came off the street. On a cold night seven years prior, he was walking from his apartment to a pharmacology class. It was March.

He spoke quickly and continuously and occasionally answered my questions.

“Where are you from?”

“Wisconsin, that’s where my girlfriend and family is from.”

“Are you feeling alright?”

“Well you see, I have schizophrenia, and I stopped taking my medicine last week or seven years ago, and I don’t know where they is.”

His story echoed a story I had heard before—diagnosed with schizophrenia, off his medication, had not seen his parents or longtime girlfriend in years, a dizzying array of cities, places, times, and feelings racing by.

Not really knowing how best to help, I suggested that he come to the emergency room (ER) with me. I thought that if I got him to see a doctor, there might be a chance for another miracle. After helping him tell his story to the triage nurse, I situated him on a bed in the hallway. Before the doctor arrived, I had to leave for class. When I came back to check on him, he was gone, so I approached the treating physician.

“Psych came down and found that he was not a danger to himself or others. We gave him a dose of his meds and told him to go to his clinic, but….” He shrugged.

I was stunned. My untrained mind screamed, “If he could do that, don’t you think he already would have done it!” In reality, I nodded and accepted the judgment of my better.

In reflecting on these events, the ER physician acted appropriately and efficiently. The ER is hardly the place to test, treat, counsel, and serve those with disabling but non-life-threatening illness. Yet, I can’t help but feel a miracle was missed. Help met trust on a cold lawn in March, but help did its job, not its calling. We had a chance to make a difference in this man’s life, and I failed. I should have found more appropriate resources for his condition. Instead, I was a naive, idealistic medical student, but I hope that some part of that idealism survives my training … because James deserves better. He deserves a physician who can recognize the opportunity to change a life by doing more than the situation demands. In the future, I hope to be that physician by not losing sight of the opportunities and using my training to become a patient advocate.

Derek K. Rogalsky

Mr. Rogalsky is a third-year medical student, Georgetown University School of Medicine, Washington, DC; e-mail: dk24@georgetown.edu.