The First Year Experience
Reflections from Students of Rutgers
Robert Wood Johnson Medical School

Edited by Prerana Chatty, Michael Enich, Lori Fingerhut, Namrata Gumaste, and Parth Thakkar

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Prerana Chatty graduated from Cornell University in 2016 after earning her Bachelor of Arts in Biological Sciences with a minor in Creative Writing. Prerana focused her narrative studies in poetry and she values the power of the written word. At RWJMS, Prerana is the Vice President for Multicultural Affairs and is a White Coat Ceremony Co-Coordinator. She is also an editor of *Arbor Vitae*, the RWJMS literary magazine. She enjoys ice cream, long baths, and nature.

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Lori Fingerhut was excited to enter RWJMS in the fall of 2016. After earning her Bachelor’s Degree in biology and history from Tufts University in 2012, Lori worked on urban health issues at the Columbia University Mailman School of Public Health. At RWJMS, when not studying diseases, Lori is an editor of *Arbor Vitae*, the RWJMS Literary Magazine. She also enjoys engaging with the New Brunswick community as a HIPHOP Project Outreach Coordinator.

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We would like to extend our deepest gratitude to everyone who worked on *The First Year Experience*. Thank you to Dr. Carol Terregino who planted the seeds of this collection, and allowed us to make it our own. Thank you to Dr. Robert Like for his continued support and guidance. Thank you to Dr. Meigra Chin for overseeing all of our projects in the medical humanities. Thank you to Drs. Norma Saks and Joyce Afran for their dedication to providing us with the very best patient-centered medical education. Lastly, thank you to Michael Briski for providing beautiful illustrations, and to all the students whose insightful pieces have made this compilation a poignant reflection on the first year of medical school.
Editors’ Note

Congratulations and welcome to Rutgers Robert Wood Johnson Medical School! We are looking forward to working with you and are excited for the journey on which you are about to embark.

Medical school is truly unique. In the next year, you will move through a series of experiences that will craft you into a more mature, capable, and resilient individual – the knowledge and understanding that you will gain will serve as the foundation for your development into a compassionate physician.

There is no one more fit to provide you with a glimpse of your first year here than students that have just completed the first year themselves. This reader is a compilation of reflections written by the most recent class of first year medical students at Rutgers Robert Wood Johnson Medical School. We personally selected and revised each piece and in order to protect patient and physician privacy, changed all identifiers, including initials, to pseudonyms. We created this collection with the hope of providing you with a lens into student experiences that define the first year at Rutgers Robert Wood Johnson Medical School.

Our reader will take you through the journey leading up to medical school, through the inner workings of the anatomy lab, to sudden realizations in the lecture hall, all the way to moments of understanding that can only occur at a patient’s bedside. We encourage you to utilize our attached reflection questions to guide your meditations on these readings, but we also encourage you to ask your own questions and to challenge the perspectives you bring with you to medical school.

Medical school is undoubtedly an arduous, oftentimes tumultuous, journey, but we hope that this reader will remind you of the gifts that it offers. The road is long, but we are excited for you to take your first steps.

Prerana Chatty, Michael Enich, Lori Fingerhut, Namrata Gumaste, and Parth Thakkar
MD Candidates, Class of 2020
Rutgers Robert Wood Johnson Medical School
Preface

What a gift these students bestow upon the school community, those joining anew, and me personally

A collection narrating the student experience,
profound and thoughtful

A validation of how we select and educate our students,
And our values,
appreciation of the human experience,
deep introspection fueling personal growth,
humility, compassion and courage.

Carol A. Terregino, MD
Senior Associate Dean for Education
Associate Dean for Admissions
Rutgers Robert Wood Johnson Medical School
Introduction

“Wherever the art of medicine is loved, there is also a love of humanity.”

– Hippocrates

“The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. The practice of medicine is an art, based on science.”

– Sir William Osler, Aequanimitas

Medical schools around the United States and globally are increasingly emphasizing the importance of the medical/health humanities in preparing medical students to become skilled, caring, and compassionate future physicians. This has involved students learning not only about the basic, clinical, and health systems sciences, but also about narrative medicine and other humanities disciplines (e.g., philosophy, languages, literature, art, music, theater, dance, film), and the relationship to patient care and one’s professional development (1-4). There are a growing number of websites, journals, and books devoted to these topics (see Appendix).

Our wonderful medical student muses who contributed to this excellent compilation of readings have thoughtfully and courageously shared their personal reflections and feelings about their first year at Rutgers Robert Wood Johnson Medical School (RWJMS). They follow in a long line of physician writers and poets, both professional and amateur, going back to antiquity (5-14).

A key question: “How can we understand humanism in medical education through how it is taught?” Montgomery et al (15) performed a literature review focusing on this topic, and proposed a conceptual model emphasizing the importance of iterative reflection and action for fostering humanistic education and clinical practice (see Figure 1).

Figure 1: The Interactive Heart and Head: Developing Humanism and Professionalism

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As described in the article:

“The resulting model centers on the interaction between the heart and the head. The heart represents the emotive domains of empathy, compassion, and connectedness. The head represents the cognitive domains of knowledge, attitudes, and beliefs. The cognitive domains often are associated with professionalism, and the emotive domains with humanism, but it is the connection between the two that is vital to humanistic education and practice. The connection between the heart and the head is nurtured by critical reflection and conscious awareness. Four provinces of experience nurture humanism: (1) personal reflection, (2) action, (3) system support, and (4) collective reflection. These domains represent potential levers for developing humanism. Critical reflection and conscious awareness between the heart and head through personal reflection, individual and collective behavior, and supportive systems has potential to foster humanistic development toward healing and health.” (pages 378-379)

As I read through the powerful, meaningful, and evocative reflections of our RWJMS students about The Journey to Medical School, Experiencing Anatomy, Connecting with the Courses, and Patient Encounters, I thought at times of Joseph Campbell’s monomyth about the Hero’s Journey and other archetypal and modern variations on these themes (16-18).

The following questions came to mind:

• What factors influenced my decision to become a physician and apply to medical school?
• What personal challenges did I experience on my journey to medical school?
• How does one cope with personal illness and/or disability both before and during medical school?
• How does one manage the vast amounts of knowledge that you are expected to learn in medical school (i.e., “drinking from a fire hose”)?
• How does one balance empathy/subjectivity and detachment/objectivity during the anatomy course and dissecting a cadaver?
• How does one deal with the “imposter syndrome” (i.e., I’m not a “real physician” yet but am being asked to wear a white coat, interview, and examine patients)?
• How does one deal with “cognitive dissonance” and “moral dilemmas” when there are contradictions between what one is taught in class and what one sees in actual clinical practice?
• How does one deal with one’s anxieties and fears, as well as ambiguity and uncertainty in medicine?
• How does one meet the enormous demands of medical school education and also maintain health, wellness, and resilience?
• How does one cultivate humility and become a life-long learner?
These are just a few of the many enduring questions your “hearts and heads” will wrestle with not only during medical school, but throughout your residency training and professional careers.

During our year-long Patient Centered Medicine 1 course, you will have additional opportunities to reflect upon and write about a wide variety of issues and experiences relating to your large group and small group class sessions, as well as your clinical encounters and community off-site visits. These reflections will be connected to the following RWJMS School-wide competencies which you should carefully review and become familiar with:

- **Patient Care**
- **Medical Knowledge**
- **Practice-Based Learning and Improvement**
- **Interpersonal and Communication Skills**
- **Professionalism**
- **Systems-Based Practice**

http://rwjms.umdnj.edu/education/competencies/all.html

The faculty, staff, and administration at Rutgers RWJMS look forward to working and learning together with you on your professional and personal journeys to becoming physician-healers. We also invite you to contribute your own reflections to this living and evolving compilation of student voices and to *Arbor Vitae: The Arts and Literary Magazine of RWJMS*. https://rwjmsliterarysociety.wordpress.com/

Welcome to Rutgers RWJMS!

*Robert C. Like, MD, MS*
*Director, Patient Centered Medicine 1 Course*
*Professor and Director, Center for Healthy Families and Cultural Diversity*
*Department of Family Medicine and Community Health*
*Rutgers Robert Wood Johnson Medical School*
References


The Journey to Medical School

“The greatest thing in this world is not so much where we stand as in what direction we are moving.”
– Johann Wolfgang von Goethe
Spades
Adiba Anam

You sit quietly in the chair, your nervousness betrayed only by what your fingers are doing to one corner of your dark green sari. Golden spades have been painstakingly embroidered all along the edge of the fabric. You trace the curves of a single spade over and over, unthinkingly. I want to say something encouraging to you. I want to tell you not to worry, but I am stuck. I cannot think of the equivalent phrase in Bengali, so I give up at trying to comfort you and sink further into the silence of the room.

The doctor walks in and I introduce myself as your interpreter, a role that I have already failed at, a role that I never quite wanted. He asks you how you are doing and you weakly smile and nod. He clears his throat, looks at you and tells you that “it isn’t looking too good.” He keeps talking, but you are no longer looking at him. You look to me, your hands finally still, your brow furrowed, questioning. I want to start as effortlessly as he had; with five words, he pulled the threads of the conversation together, like fishermen pull their nets out of the cold abyss.

“It isn’t looking too good.” Bhalo dektehseh na. I mull over this phrase, feeling deeply unsatisfied. It is something that my mother has said to me over the years, when I have made questionable fashion choices. It is not what I wanted to say to someone who may be going blind at 55. I say them to you anyway. I mention that the doctor wants to do more tests, more procedures, but you are no longer listening to me. You are back to tracing golden spades.

Back in the car, I call my mother and tell her what the doctor said. She tells me to bring you home so that she can discuss things with you. I drive with the windows down, glancing at you from the corner of my eye at every red light. You are always so quiet. I ask if you would like to get something to eat on the way home and you start to cry.

A string of expletives race through my head followed by a sense of horror, like somehow my question had broken you. I pull over and turn to face you. Before I can speak, you grab my wrist tightly. You tell me you are sorry for crying but that you are scared. You tell me how you want to be able to see your sons, your grandchildren. You tell me you do not want to be a burden. You ask me if life holds any meaning when you cannot see your loved ones.

To all of that, I say ami jhanni na. I don’t know. I place my hand on top of yours and say it again. I tell you that your family loves you, that you would never be a burden to us, that we would figure out what to do. The words flow smoothly, no hitches in interpretation this time, and I am so grateful for that. We let go of each other and I hand you some tissues. You wipe away your tears and adjust your sari. Sunlight hits the golden spades, casting iridescent scales on the interior of my car. It is random and carelessly beautiful. This little scene may be lost to you too… but I dare to hope it won’t be.
Finding My Purpose

Anonymous

I have always been interested in the medical field. The intricacies of the human body, the research that goes into drug development, and the new discoveries that are made have never ceased to amaze me. Medicine is always changing, and I have always wanted to help enact that change. However, I only found an underlying passion that now drives this dream after I graduated from college.

After college, I returned home eager to begin my job and enjoy my gap year while applying to medical school. Exactly a month after graduation, and on my first day of work, I sat at my lab bench trying to pipette, but I realized this basic lab task was significantly more painful than it had ever been. That night, I was not able to wash my hair either. I stared at my hands, swollen and red, from what I assumed was my hot shower, and thought the pain would disappear in the following days. Instead, the sharp, debilitating pain in my wrists quickly spread to the rest of my joints. I sat back as the grand plans I had for my gap year quickly began to unravel.

Within a month, I had more blood tests done than I could count, and I had three MRIs and four X-rays. Each time, my results came back normal. I saw six doctors, each referring me to the next because they were stumped by my presentation. I was 22 years old, had joint pain so severe that I could not walk or hold a pencil, and no doctor could solve my case. Over the course of two years, I cycled through over fifteen medications, some of which required me to inject myself twice a week — and I did not have a positive response to a single one of them. Some autoinjectors left huge bruises on my legs. The delay from the click of the injector pen and the needle digging through my skin caused me to pull the needle out before I received even half the dose. After an unsuccessful attempt, I looked at my medication sprayed across my bedroom floor and finally garnered the courage to ask my doctor if I could come to his office for help (he had previously said that I was “too anxious,” which scared me from bothering him with a simple problem). He replied, instructing me to watch a YouTube video, so I eventually resorted to having my roommate inject me.

I am grateful my diagnosis is not life threatening, but my seronegative rheumatoid arthritis has made me acutely aware of how different I am from my peers. When I first started experiencing symptoms as a 22 year old, I needed help taking showers. On my 24th birthday, I had to leave my party early because the pain in my feet was so excruciating that I could not bear to stand on them anymore. To this day, I must think about how I pick up objects with my hands, how long I plan to be on my feet, or how I turn doorknobs. When planning vacations with friends or family, I am always the limiting factor.
Through all of this, my drive to pursue medicine has only intensified. Being the patient has taught me the power that a physician has to affect someone’s physical and also mental wellbeing. After two years of unrelenting pain and poor responses to my medications, I looked to a new rheumatologist for a second opinion. At the end of my appointment, the doctor turned to my mother, completely disregarding me, and said: “at this point, do we believe the patient or think that they’re making it all up?” I had never been more offended. I was the patient, not my mother, and he was not even addressing me. He was speaking about me as if I was not in the room, and on top of that, he was belittling months of loneliness and isolation, the pain that kept me home from work, and all the effort I had put into my treatment. I never returned to his office again. This experience ignited within me a drive to validate patients’ experiences and treat them with the respect and dignity they deserve. No one should feel the way I did walking out of that appointment.

Soon after, I followed up with my regular rheumatologist. Every time I came into his office, I would ask about my prognosis and whether applying to medical school was realistic for me. He was always optimistic, telling me that I still had time to wait and see, and in the worst-case scenario, I could defer for a year. This time, however, I walked into the exam room, and he declared that my lack of response probably meant that I had refractory rheumatoid arthritis – this meant I would never respond to medications or improve. He did not realize the weight of his words, but they crushed me. I went home and cried for hours. To me, that meant my lifelong dream was gone. I do not fault him – I think it was difficult for him to fully understand my position – but to me, my one champion, the one person who was always optimistic, and the one person I relied on to restore my health, had given up on me. To me, that meant all hope was lost. I do not think he will ever know what it feels like to be in your early 20’s and essentially be told that you will always be reliant on your parents or a caretaker, especially when you so vividly remember your previously independent lifestyle.

My experiences with countless doctors, both positive and negative, were not at all what I expected for my gap year, but ultimately, I am incredibly grateful for them. They sparked a deeper, emotional connection within me to the field of medicine. I learned that every word you say as a provider can have a profound impact on your patient. With this realization, and my own experiences as a patient, I now pursue medicine not only for my fascination of the human body, but because I want to be the doctor who advocates for their patients. During turbulent times, I want to help patients learn how to redefine their identities and make the most out of what life has handed them. I still hope to enact change, but now I aspire to do so on a more personal, patient-centered level.
Reflecting, “Fast and Slow”

Parth Thakkar

When I first received the phone call from Dean Terre gino relaying my acceptance to RWJMS, I had two immediate reactions. The first was an enormous sense of gratitude – all of my hard work had finally come to fruition. After the initial buzz of excitement passed, however, I felt a sense of hollowness. This concerned me. Why had the culmination of all these years not provided me with a genuine sense of achievement? Where had I gone wrong? I needed some time to think. I requested a one-year deferral to search for answers.

My B.S. in a joint program of Cell Biology and Neuroscience (CBN) provided me with a training honed in on the circuitry side of human behavior. During college, I failed to realize that delving into the human condition appealed to me more than tracking the influx and efflux of ions. Daniel Kahneman’s Thinking Fast and Slow, a book I read during my gap year, helped me reassess my interests and passions.

Kahneman discusses intuition and the ways in which our subconscious affects our decision-making. With his background in psychology, Kahneman changed the way we think about human rationality. By distilling decades of academic research, he offered insight about our biases and the dichotomies of emotional and logical thought.

As I read the book, my mindset evolved. I realized that even though I find time to reflect, my meditations are not necessarily true. That idea troubled me – how could I develop a way of looking at myself that was honest?

Understanding how we explore our self-narratives became particularly important to me during this time. As I reflected on my college experience, the one word that came to mind was contradiction. I had followed the advice of mentors who told me what “I had to show medical schools” to gain admission – an aptitude for upper level biology courses and a competency in scientific research – yet I did not feel any closer to an inner passion. Medicine was alluring to me because it provided an opportunity to become a humanitarian while also wearing a “scientist's hat.” Yet as I sat there, on the cusp of graduating from college, I felt as if I simply used my education as a means to an end. I felt like a fraud and I did not feel fulfilled. I did not feel that my scientific education was a sufficient foundation for a medical career and I was unsure if I should even continue down the path I had carved out.

That is where Kahneman came in. Thinking Fast and Slow offered me a new way of looking at my experiences. Kahneman offered me a framework for why the emotions we experience in moments do not always match those of our memories. He made a distinction between our stream-of-consciousness “experiencing self” and our memory-building “remembering self.”
If I had kept a journal of my experiences in college, I think it would have been filled with entries about coping with challenging academic curricula, overcoming obstacles both inside and outside the classroom, and enjoying life as a young adult. This journal could have served as a way to peer into the thoughts of my experiencing self. Instead, my “remembering self” was now marred by insecurity and doubt, and it projected a fractured version of myself onto my college experience. Disturbed by the emotional weight of the poor decisions I thought I had made, my college “experiencing self” felt like a stranger to my present “remembering self.” I was unable to think clearly, and the only thing that I knew was true was how I now felt – broken.

However, my ‘remembering self’ also helped me create a new narrative for myself. Kahneman helped me understand that I had not wasted time in developing a strong technical proficiency in the sciences. For any physician, science provides the backbone of their humanitarian role – because I had developed a strong foundation in the clinical sciences, I could now spend time developing projects in the humanities during medical school. With this reframing of my story, I was at peace with myself, and I felt ready to move forward.

That is the beauty of self-reflection. The stories that we weave about our own experiences, like the narrative I told myself about my time in college, are not set in stone. Reframing our self-perception helps us dissect and understand our own circumstances, so we can more honestly engage in self-interpretation and become resilient.

By broadening our experiences, we are able to reexamine our purpose. Kahneman helped me constructively find a place for my CBN degree and to create a path for myself in medical school that provided me with meaning. It was as if he held up a mirror and helped me to truly see myself.

I learned that to look at myself honestly, I have to stretch my imagination, peer through different lenses, and change my pace. All I have to do is keep reflecting, “fast and slow.”
The Highway

Michael Enich

I fancy myself good with young people. After graduating from a school in rural Minnesota, where I had accumulated all the pre-medical merit badges of research, shadowing, organic chemistry, staying up late, and a pinch of self-loathing, I decided to dive straight into the heart of the “real world.” I moved to Newark, New Jersey to work at a shelter for young people experiencing homelessness.

With homelessness came a wide variety of issues, and I was ready to put my liberal arts education to work solving multifaceted problems out on the streets. Thank goodness I had taken those classes on American Culture. Otherwise, how could I understand the American Dream narrative and the expectations it engendered on young men to provide for themselves without assistance?!

The year I spent in Newark as a Jesuit Volunteer is its own story; after finishing, however, I moved back to Minnesota to work in a psychiatry office claiming another merit badge (The “I lived in an intentional community across the country and learned to love a place that is so often misconstrued as solely violent” badge). My new job was pretty mundane, consisting of writing notes and faxing papers mostly.

Imagine my excitement when a parent approached our desk at clinic one day and said, "My son just walked outside and is refusing to come back in for his appointment." Ready for action, I decided I would use all my acquired skills to get him into his provider’s office.

I threw on my nice little pea coat and marched outside, only after assuring the mom "I worked at a shelter last year. I have some experience getting oppositionally-defiant young people to do things they don't want to do." I sauntered out pretty self-assured-- don’t worry, this future child and adolescent psychiatrist is on the way!

You can guess that my attitude did not get me very far.

YP (Young Person) was in the low teens, a cisgender male, and had recently been in the hospital. He was leaning against his mom’s car with his hoodie up, staring at the ground.

"I'm Michael, and I hear you don't want to come into clinic."

There was no response.

"Any particular reason why?" I asked, deciding to mirror his leaning.

"I'm tired and don't want to today." he responded.

"Got it." I replied, "I hear you want to just go home and play video games." I tried to start a small conversation about popular games and the one I had most recently played.

"I'm not giving you anything."
I should have trusted his word. He knew what he was doing--more importantly, what I was trying to do--and neither of us was really getting anywhere. I had intentionally wandered into a power struggle in the parking lot. Since I came to him, he was most definitely in control, and I learned last year that you do not take power from a person who is vulnerable.

Instead of heeding the warning signs, knowing what he said as true, I sat in anxious silence, trying to figure out what perfect phrasing would magically get him to give it up and come back inside. I had fabricated this scenario as a test for myself, another task to win for the list. This was it. The final ultimatum, as it were. My way or the highway.

As I delved into possibly the most generic, cringeworthy "Our providers really want to help people..." he definitely did not choose my way. In fact, he chose the highway.

Literally.

We were not far from a country four-lane road and with a decisive "Fuck all of this!" YP kicked off his flip flops, crossed the noise-protecting shrubbery and cemented himself on the double yellow lines.

Luckily, there were no cars and he wasn't injured; He did make the choice, however, to put himself in harm's way because of the choices I made to come out there and talk to him.

Later that day, I went to talk to my own therapist. "What convenient timing!" I said in the door of his office, still kneading out the interaction in my mind. I ruminated a lot about what I could have said or done differently. I scolded myself for foolhardily thinking I had some magic knowledge set that no one else in our clinic had.

"In my years of working in mental health," he said, "I have learned the number one rule: never chase clients."

A year later, I'm asking myself: how could I not jump into the struggle with YP? I am drawn to medicine by the people who, in my view, need health most. Youth draw me in because of how much opportunity they have to grow. After seeing young people forgotten about in Newark, staff giving up on their goals, patients whose psychiatrists stopped following up because of lack of adherence... It was more than braggadocio that lead me into the parking lot. It was a sense of responsibility for the forgotten ones.

And knowing that I would not be here if someone had not hugged me closely, encouraged me and drawn me in in a parking lot 11 years before.
Baby Steps

Lori Fingerhut

You have to walk before you can run.

I learned how to walk twice in my life – the first time when most do, around age 1. The second time, I was 15. With support from the hospital’s physical therapists and nurses, I shakily rose to my feet for the first time, over a month after my accident. Torso secured in a plastic, white “turtle shell,” arm wrapped in a splint, I had no choice but to lean all of my weight on a walker as I tried to move my left leg forward.

It did not go well.

My leg was limp from paralysis and atrophy, my body weak from 6 weeks of surgeries, pain, infections, drugs and lying in bed.

Life does not prepare you for how to react after a life-altering multi-trauma. Had I expected to run? Probably not. Had I expected it to be that hard to take the few steps between my bed and the wall of a small hospital room? Also, probably not.

But was my naivety that surprising? I spent the first 15 years of my life running, my pace a product of inner drive, external validation, and family expectations. I moved quickly from school, to softball practice, to piano lessons, using whatever time I had outside of those activities challenging myself to be better at, well, those activities. I chased goals, and honestly, I struggled very little to achieve them. Running came naturally, and why walk when you could run?

All of a sudden, walking did not come naturally anymore, let alone running. I simply did not have the muscle strength in my legs, abs, or back to support my own body weight. I limped my way through high school and college, putting more energy than I knew possible into standing, balancing, and flexing muscles. Still, over the course of 3 years, I rediscovered how to coordinate my movements. I progressed from a walker, to forearm crutches, to a cane, and finally only a leg brace for support.

In hindsight, I did not take my inability to run very well; in some ways I did not take it at all. While I figured out how to walk again physically, my head still craved the run.

I wanted to graduate high school with my peers despite missing over 3 months.

I wanted to go to a top college.

I wanted to finish my premedical requirements so that I could apply to my school’s early assurance program.

Barring that, I wanted to apply my senior year so I would take only one gap year.

I was like a person pedaling ferociously on an exercise bike, convinced it would eventually move if I tried hard enough. I chose my destination and took off without looking back. I never gave myself time to focus on healing or understand the challenges of my new life. When I
experienced unfamiliar struggles with schoolwork, I never slowed down to pinpoint their roots. I never found different hobbies or passions to replace the ones I lost with my accident. I tried to run past it all.

I may have been on a road – to adulthood, to medical school – but by junior year in college it was clear I was not going anywhere. I felt exhausted, defeated, and lost. I was frustrated by my difficulties and confused by my inability to conquer them. So at last, I stopped. I truly contemplated how to move forward. I could keep on pretending to “run” through the weeds, or I could slow down, take things one step at a time, and find new ways around the weeds. I chose the latter, and it was one of the best decisions I have ever made.

I finally began to learn how to compensate for my weaknesses. I started to question. What was I good at? What did I actually enjoy? Why did I even want to go to medical school? I considered the fact that I actually liked my history major more than my biology. The science of the human body fascinated me, but I possessed an equal, if not greater, appetite for stories, narrative, and the people to whom they belong.

I spent four years walking this path, rebuilding, searching for meaning, trying to better understand what is important. I found a place where my interest in health and passion for context and history intersected: public health. I learned about communities, why individuals get sick and stay sick, and where opportunity exists to make a difference in health, healthcare, and people’s lives.

Everything on my journey pointed back to people and their narratives. Narrative is what both drove me away from the medical school path, and then ultimately brought me back. Medicine, I realized, is not just biochemistry, cells, organ systems, memorizing drug and disease names. That is only what lies beneath the skin. A patient’s livelihood and wellbeing are in their stories and environment: the places they have been, the food they eat, the schools they attend, and the families they cherish or wish to build. Good doctors do not only prescribe medication or perform surgery; they seek to understand how their patients got to where they are and also where they want to go.

I was a 15-year-old girl that got crushed under a falling tree, a pile of broken bones that needed fixing. But I was also a teenager with a family, a dog, a previously active lifestyle, an interest in music, books, and science and medicine. My doctors asked me about my life, my school, and my dreams. They explained the science behind my injuries and sent me books in the mail (that I still have).

I told them that in the future, I hoped to be a physician.

“You’ll get there,” one doctor said, “it might just take you a little longer.”

He was right. I am now at RWJMS, on my way to becoming a physician. I just had to learn how to walk first.
**Questions for Reflection**

1. In “Spades,” the author describes a tragically beautiful encounter with a patient. Reflect on the line, “You ask me if life holds any meaning when you cannot see your loved ones.” How do you think disability affects the way one perceives a fruitful, meaningful life?

2. In “Finding My Purpose,” the author notes a lifelong interest in medicine. However, after experiencing debilitating illness, and subsequent negative interactions in the medical field, the author truly finds purpose in the calling towards medicine. What is your purpose, and what calls to you in medicine?

3. In “The Highway,” the author recognizes the limits of his own knowledge when interacting with a particular patient. Instead of allowing this setback to deter him, the author reflects on how he feels responsible for the forgotten ones—as he once was many years ago. How have personal setbacks driven your journey towards medical school?

4. In “Reflecting Fast and Slow” and “Baby Steps,” the authors pause on their goal-driven paths to answer important questions about themselves and the trajectories they wanted their lives to take. In the end, they realized it was narrative that drove them towards medicine. Have moments of slowdown in your quest towards medicine helped to illuminate what the journey truly means to you?
Experiencing Anatomy

“I learn…anatomy not from books but from dissection, not from the tenets of Philosophers but from the fabric of nature.”

– William Harvey
Dear George

Prerana Chatty

Esteemed physician-poet William Carlos Williams once said, “when asked, how I have for so many years continued an equal interest in medicine and the poem, I reply that they amount for me to nearly the same thing.” Like William Carlos Williams, I see my world in poems.

My study of poetry began in college. As I decided to pursue medicine, I used poetry to process my clinical experiences – medicine is unique from other sciences because human interaction is at its core. Poetry helped me bridge these elements of science and humanity.

Before I entered medical school, I recognized the anatomy lab as a sacred hallmark of my training. In my final poetry portfolio of college, I wrote a poem in the form of a letter to myself, ending with the lines “there are bodies waiting for you to open them/so open your hands.” A few months later, as I began anatomy in medical school, I braced myself for life-altering experiences and for self-reflection. I was not disappointed – the anatomy lab was a world of poems.

My first moment holding a human heart inspired the line “the heart was meant to be handled.” The moment when I found a pancreatic tumor in my donor, a few weeks after my grandfather was declared a pancreatic cancer survivor, birthed the lines “I am holding in my hands a pain so deep/it creates/what it takes.” Above all, there was a moment where I was looking at a donor with my classmates, and we forgot her skin tone. This inspired the line “when they ask me who I am, I know only that skin is a mask.”

This poem is about the first donor I worked with – I called him George. I think many of my classmates would agree that our first donors were particularly special to us. They were our first patients as we began the whirlwind anatomy lab experience. I certainly felt this way about George. I really felt that we were partners in this journey.

I thought a lot about what George was like – what his job was, who he loved, or even what his favorite color was. George had a neurological impairment when he passed away, so I thought a lot about whether he remembered, in the moments leading up to his death, that he had chosen to donate his body. I wished I could thank him.

I had a hard time wrapping my head around the fact that George wanted me to learn from his body, so the first day of anatomy lab, I held his elbow before leaving, the way I might hold my grandfather’s when helping him down the stairs. I wanted to maintain a human connection with George in spite of how abnormal I knew things would quickly become. This gesture became a habit every time I left the lab. It made our relationship more real.

This poem is directly about my experience with George, but I hope that it also speaks generally to the student-donor relationship. All of our donors and their families helped create the next generation of physicians. As a first year medical student, nothing could be more humbling.
Dear George,

In this new life,
there is no forgetting –
only a girl in green scrubs
memorizing you
with her hands –
a girl praying with her palms on your back
– then an incision.
Your skin unraveled
her eyes unraveled you.
(she breathed in)
She swore there was green in your eyes.
(she breathed out)
She searched for you in the numbness.
When she could not find you,
she grasped your elbow.
You ran through her

like a current.
She remembers the “M”
she found in your axilla
like a resonating chord.
Her chest resonated (she breathed in)
as she opened your atria
with her fingers (she breathed out)
– she looked for absence,
    she learned your presence.
Her fingers followed your sulcal grooves.
They memorized they remembered,
she grasped your elbow.
You pierced her like static,
nothing static about you.

She learned you like a language.
The deeper she cut,
the deeper she loved you.
The deeper she cut,
the deeper
she remembered the green
in your eyes.

She sat by you,
praying with her palms on the remnants
of your palms –
when she left you,
the girl in the green scrubs
grasped your elbow
(she breathed in)
She memorized
(she breathed out).
While in the anatomy lab, there were a few tools I used to make it through. There were the physical ones, of course—scalpels, scissors, hemostats and "Grabbies" as I called them—and the more subtle verbal ones I learned along the way.

I likened anatomy to surgery at the time and surgery was the one specialty I always ruled out; when we switched lab groups at the beginning of a new set of dissections I dutifully informed my new teammates of my intention to become a psychiatrist and warned them that this "word surgeon" would most likely get in the way more than he would help.

The first time I shadowed in an operating room was for a valve replacement. One early morning, I essentially broke into a Post Anesthesia Care Unit (with permission, just for clarity) by stalking a scrub nurse through the locked door. Once infiltrated, I began the familiar pre-med ritual of sitting in corners until someone noticed me and cared enough to push me off to another corner (of someone else’s jurisdiction). Eventually this dance got me in scrubs, with the patient, into the Operating Suite and on top of a stool. Once there I was told 1) to not cross the curtain and 2) sit on the floor if I felt faint ("There's only room for one sick patient in this room, sweetie!"). I dutifully stood there for six hours without moving, eating, peeing OR passing out because I was afraid any move I made could kill the man on the table.

I will take this obligatory moment to say yes, it's pretty incredible to watch a heart stop, get cut up, sewn up, and start up again.

I, personally, do not feel as though it was worth standing for six hours to watch. Smelling burning flesh, hearing cracking bones and feeling the jittery edge of stillness waiting for a heart to start again was enough emotional turmoil for me.

Give me, instead, the delicateness of well-crafted sentences, the locked door of words a patient can construct and the key of phrasing that can unlock them.

With this experience in the back of my head, I acted as my lab group’s charmer. I read the dissection instructions every night before lab, absorbed nothing, and (graciously) relied on my partners to guide me through the pile of knowledge that is a human cadaver.

I will take this obligatory moment to say yes, it’s a pretty incredible honor to dissect what was (or is, or once housed) a human being.

I, personally, do not feel as though anyone could have prepared me for the gross-ness of it. Smelling preserved flesh, physically cracking ribs and feeling through layers of skin and fascia purveys information and is awesome (in the traditional sense) but also makes for strange dinner conversations. Getting to know the intricacies of humanity like this made it hard to interact with other living humans. Not knowing what else to talk about one evening, I told my non-medical
school friend Hannah that I sawed a human head in half that afternoon. She responded with “Why on earth would you tell me that?” I realized some days’ stories were off-limits to outsiders.

These thoughts and experiences left me with an emotional cocktail of awe, discomfort, freedom, humility, ignorance and confidence. All I knew leading up to a given dissection was that I knew nothing. At the table I could feel that what I valued in humanity (and also in medicine) was gone; there were no conversations to dissect or string back together again. In a strange way, because I could be confident that this person was gone I gave myself the freedom to do what many other of my classmates were afraid to: I made the very first cut. I pulled the skin off of hands. I “bifurcated a skull”... in two planes, nonetheless.

At the beginning of the course we were told that we would all have at least one “moment” where we were smacked with the absurd reality of dissection. I interpreted this as having a moment where we would be reminded of our own mortality and acutely asked to grapple with it silently in front of peers, at strange intervals-- when you noticed, for example, that her nails are painted or saw a patch of hair on what is left of someone’s scalp.

For me, this came when I had a bone chisel in one hand and a hammer in the other. The jittery edge of the chisel was momentarily still and positioned at a right angle to the cadaver’s spinal column. My group waited. With one strong, decisive thwack I cracked the lamina. I heard the sound of bones breaking at my hands for the first time. I felt both how much force it took and how easy it was with the right tools. I peered into the incredibly thin layers of dura beneath. As if in a movie, I suddenly understood the surgery my dad had two weeks before we started lab. The unknown name of the operation that failed me at the time, lost in a sea of new vocabulary, now settled in my consciousness: laminectomy. In an operating room halfway across the country, a surgeon had stood like I did and mirrored that performance on my father. He was trying to return sensation and motor control to my dad’s right arm, the one he used to count pills as a pharmacist during the day and strum a tambura at nights. I remembered that a few tables away, there was a donor who had died during a spinal procedure; on the first day we had reached into the column with our fingers, feeling the vacated space. For a brief moment I was speechless, seeing, now knowing, what could have happened with the slip of a chisel.

In this silent moment, this word surgeon felt numinous awe, discomfort, and humility met only by the specter of a true surgeon and the wordless moment of humanity.
Ageusia

Erica Concors

The entire month of November was yellow.
Not soft yellow, like an oil painting of a lemon tree hanging in your Dentist’s office.
Yellow-yellow.
Like looking directly at the sun
The kind of yellow that clings to the little hairs in your nostrils and surprises you four months later in the middle of a conversation about another friend of yours who got engaged while your head was trapped inside a textbook.
It’s not easy to face what we really are under all that skin and pretense.

So, you avoid scrambled eggs.
You avoid your family.
You think this helps.
Sometimes it does.

December was royal blue: Tide detergent and discount body wash.
I tried to scrub the smell of you away,
But my hands knew what I had done.
They carried their history with them.
They practiced life and death and what comes next,
Ten rays of light pouring into the dark abyss
Illuminating the chasm/cavity between us.

January came for me with muted white expanse
Like cotton-balls stuffed in your ears, the snow absorbing all the sound
Until even the moths feel lonely.
But you can’t avoid all the foods that look like dissected flesh (even a peach will turn against you in the wrong light).
So you become an expert on eating with the lights off,
And eventually another friend gets engaged and you have to call them back and say “Congratulations,”
even though you could still see the indent on the half-intact ring finger you cut into last Thursday.
And when your friend asks you what’s new, you don’t say, “I’m eating meat again, but only hidden between two slices of bread.”

And suddenly it’s April fifth,
You’re eating two eggs (over-easy)
And laughing at the joke your mom just texted you
Even though it was bad.
When the rain comes that spring,
warm with redemption
You can’t help but notice the reds, the greens, and all the rest.
Tiny fractals of light pouring through the droplets.
All those colors
But you are nowhere else. You are here.
Questions for Reflection

1. In “Dear George,” the author describes how she held her cadaver’s elbow before leaving the anatomy lab as a means of maintaining a human connection. How do you think the experience of anatomy benefits from acknowledging the humanity in each cadaver?

2. In “Word Surgeon,” the author’s views on surgery change from indifference to numinous awe. Have you experienced a defining moment that changed how you viewed a particular field or person?

3. In “Ageusia,” the author describes a jarring reality where nearly everything returns to the anatomy lab. Indeed, at times anatomy can feel all encompassing. By the end of the poem, the author seems to re-enter life as it once was. How do you think the experience of anatomy will change you, and how will you contend with this change?
Connections to the Course Material

“Human knowledge is never contained in one person. It grows from the relationships we create with each other and the world, and still it is never complete.”

– Paul Kalanithi, *When Breath Becomes Air*
Medical Student’s Disease

Gregg Khodorov

**Medical Student’s Disease**: a condition frequently reported in medical students who perceive themselves to be experiencing the symptoms of a disease that they are studying.

It’s real. I first heard about it during medical school orientation—it was passed down as an urban legend, a cheeky story handed off from the second year students as they showed us the school, explaining that we would spend exorbitant quantities of time learning each and every nuance of the human body as we made the slow, deliberate transition from students into young physicians. I am sure their orientation guides told them a similar story about Medical Student’s Disease, and how someone’s cousin who was a first year medical student at a different school had a stroke just as he was learning what a stroke was in class…

Then, five months into my first year of medical school, hours after dissecting a cadaver’s heart, I find myself in an urgent care facility for a tight chest and some trouble breathing. As the automatic blood pressure cuff inflates, I half-jokingly explain to the nurse that I have a feeling it’s just a mild case of Medical Student’s Disease, and that I have become, as of late, acutely cognizant of my heartbeat and my breathing.

This awareness has recently heightened, as I have just learned about the importance of atrioventricular pressure gradients in correctly directing blood flow through the heart and body. I tell her what I have found most fascinating since starting our new cardiovascular unit is the role of high and low pressure baroreceptors (literally pressure sensors in your body designed to read and report any slight changes in blood pressure to your brain) in maintaining proper blood flow throughout our various daily activities.

The nurse does her best to sound interested in what I’m saying, and then looks at my blood pressure—144/80. She proceeds to inform me of another condition, called **White Coat Hypertension**, in which patients, upon entering a healthcare “white coat” setting, exhibit higher blood pressure than their normal metabolic rate simply as a result of the added stress of a clinical environment. Meanwhile, I am trying to process my high blood pressure—I have never been one to deviate far from the normal 120/80. The doctor comes in and asks me about any family history of heart conditions. Knowing this question is part of a standard medical history questionnaire, I am happy I texted my parents earlier in the day and collected a full list of heart conditions on both sides of my family.

The doctor asks me if I have recently experienced any increased stress. To this, I simply reply, “I’m a medical student.” He smiles gently, and nods, asking me to breathe deeply as he listens to my lungs. I breathe deeply, but only until I feel his stethoscope deviate from my lungs, as he repositions in order to listen to my heart sounds, an exam maneuver I had learned earlier in
the week. I recognize the pattern of the stethoscope moving on my chest to listen to the four valves of the heart: Aortic, Pulmonic, Tricuspid, Mitral (APT M, or “Apartment M” is a great mnemonic to remember which sound is which).

The doctor leaves, telling me he will be back after a chest X-ray and EKG are taken to further analyze my heart. The irony of my having skipped the 3-hour EKG lecture earlier that day suddenly fills me with the endless regret of not having worked hard enough this past week (a feeling which I am confident every one of my classmates has battled on more than one occasion). I call after the doctor, asking, “I’ve been taking calcium supplements lately, I’m wondering if I may have messed with my cardiac contractility…” (I recall the lecture in which we discussed the importance of calcium in allowing the muscle fibers of the heart to contract properly.)

He turns at the door, replying, “That’s no problem, that’s fine.”

Upon walking into the X-Ray room, the technician asks me to stand with my chest facing the board. I tell her I cannot wait to see these images. She asks if I have ever had chest X-rays done on me before. I reply, “I think I have, but definitely not P-A images like this”. She doesn’t respond, and I wonder if “P-A” is even a clinically relevant term, or if this term for the position of the body between the x-ray and the film—which I learned only a month before—was already somehow outdated in real clinical practice. I hold my breath and stay perfectly still as she takes my picture with her fancy X-ray camera from multiple angles. I really want these to be the best X-rays I have ever seen.

As I peek over the doctor’s shoulder to see my near-perfect images, he coyly asks, “Well, what do you see?”

“That’s a heart, alright,” I reply, not noticing any major indicators, and too proud to reveal my ignorance.

The doctor glances over at my EKG, and tells me plainly, “Your EKG has some PR depression and mild ST elevation, usually consistent with pericarditis, a fluid accumulation caused by inflammation of the pericardium—most likely caused by a viral infection. It sounds like it’s pretty acute for you, since it’s only been a few days. Sometimes, if it’s severe, you can drain the fluid, but I doubt if we tapped your pericardium, we’d even find any fluid. Some Motrin for a few days and you should feel better.”

“Is Advil okay?”

“Yes, Advil is fine.”

Pericarditis… The day before, I had cut the fibrous pericardium surrounding the heart with scissors, as my classmates pulled on the tissue with forceps, for traction.

Before leaving, I ask him to repeat slowly what he noticed on my EKG, so I could write it down and come back to those words after catching up on my skipped lecture.
Ventricular Fibrillation

Namrata Gumaste

An EKG is a recording of the electrical activity of the heart. With each twisting pump of muscle, an entrancing set of rhythmic waves is translated to paper. There are times when these beautiful patterns give way to chaos. In ventricular fibrillation, the heart is drowning in electrical mayhem—quivering erratically instead of pumping out blood to the body. In many cases, it is the final EKG pattern seen before the line goes flat. When we learned about ventricular fibrillation, I thought of a book I had read the summer before coming to medical school, *When Breath Becomes Air*. Author Paul Kalanithi noted that one night, his girlfriend burst into tears while studying EKGs—she realized that wherever this textbook example had come from, the person had not survived. Looking through reams of EKGs, the pathological patterns blurring into mysterious scribbles, I too found myself wondering: who were the patients behind these lines?

**Ventricular Fibrillation**

I traced your line: howling peaks and troughs, the final angry protests of a failing heart. In that line I felt your rage, the frantic race—a storm falling corkscrew from the clouds until all that’s left is static, a breath disappearing into the cold night air. I must have known you in another life: your penchant for lottery tickets, the wide framed glasses you wore, the way you would sneak an extra sweet after dinner. How strange it is to mourn memories I do not have. But I believe I remember you, I do. Here your life comes down to a line and I find myself turning to the sky, into that celestial void, wondering where, far or near, it all began.
Type 1 for an M1

Keith Diamond

The “90/10 Rule”: Life is 10 percent what happens to you and 90 percent what you make of it.

After years of hard work, I was thrilled to finally be enrolled at Rutgers Robert Wood Johnson Medical School. My friend’s father, Dr. T, jokingly forewarned me that he was afraid to waste time even to go to the bathroom during his overwhelmingly busy first month of medical school. Needless to say, I entered my first semester anticipating a lot of studying and stress.

Dr. T was right. The first few weeks of medical school were certainly intense. Material that I was supposed to understand accumulated faster than I could learn it. Still, I made sure to exercise, do yoga, cook and eat healthy meals—frankly, to take care of myself.

Despite all of my self-care techniques, after a few weeks, something just did not seem right. I stepped on a scale and discovered that I had lost twelve pounds in just one month. I was eating well, I was exercising, and I was getting adequate sleep—so this, literally, did not add up. Moreover, despite drinking sometimes copious amounts of coffee, I could neither focus nor stay awake through a single lecture. I felt like I was falling apart from the inside out.

The weekend before my first final exam of medical school, I decided to see a doctor, hoping to be reassured that my physical symptoms were simply a manifestation of stress. With that diagnosis, I was sure that I could make myself relax and combat my ailments.

It was not that simple. When the nurse heard my symptoms, she asked for a urine analysis. Shortly after the test, the doctor came in and told me that my urine analysis revealed a high sugar content. I countered, “I just ate breakfast,” but the doctor did not bite. He quickly replied that my glucose was much higher than it should be, even after a meal. To confirm his initial analysis, he then tested my blood sugar, which measured 374 mg/dL.

The doctor looked at me very somberly and told me that I have diabetes. He then excused himself from the room to fetch the grocery list of prescriptions I would soon need. Just like that, the ball was dropped.

As I sat in the exam room, my mind was racing through shock, denial and admittedly some panic. I started Googling life expectancy, co-morbidities, and other associated risks with diabetes. I was thrilled to find that I was now at an increased risk for stroke, heart disease, liver failure, limb amputations, and many more complications with my newly discovered condition. I was alone in that room for what felt like an eternity.

The doctor returned with a mountain-sized pile of papers and a list of prescriptions that seemed endless. I needed insulin, lancets, a glucose monitor, needles, alcohol swabs, and test
strips. He gave me phone numbers for dietary counselors and an endocrinologist. He gave me a second set of prescriptions for blood tests that I would need including an HbA1c, lipid panel, and c-peptide… it went on and on…

While he was explaining the gauntlet of things I needed to do, I felt like I was in a Charlie Brown episode. The doctor was just saying “blah, blah, blah”, and I was not registering any of it. Not a single word. I asked him to repeat the instructions two more times, and then practiced reciting them back to him. The doctor was very patient. I must have been nodding blankly, because he gently added, “I don’t know how you feel right now. I’m sure this is very overwhelming and I’m here to help in any way.”

It all hit me when I left the doctor’s office. I walked in circles, dreading the phone call with my parents. My mom picked up and said, “Hi Keith! Excited to celebrate your birthday tomorrow! How is everything? Good?”

“Actually Mom? No. Everything’s not good…”

My dad joined the phone call, and I began to regurgitate the sequence of events. During our conversation, I was swept up by the volume of my tasks and the uncertainty of my future. My mood snowballed into a fusion of anger, shock, frustration, anxiety, and fear.

Though my parents were definitely surprised, they calmly told me that we would find a great doctor and that everything would be okay. All I wanted to do was to ignore this unfathomable discovery and bury myself in studying for my upcoming, ever-so-important, exam, but I couldn’t – not yet.

Fortunately, Dr. T put us in contact with an endocrinologist whom he trusts, and my mom, dad, Dr. T, and myself, joined a conference call with this specialist within an hour. The doctor explained the procedure for administering insulin, elaborated upon what I was allowed to eat, and quieted our immediate concerns. We were delighted to hear that he would make time to see me early the next morning.

It wasn’t until after we hung up with the specialist that I could finally take a deep breath and slow the spinning of my mind. This single telephone conversation served as an anesthetic to both my parents and me, and after my appointment the following Monday, I actually felt empowered. My endocrinologist’s words gave me confidence that while diabetes presented a new obstacle in life, I could choose to view my diagnosis as a challenge rather than a burden.

I am fortunate to have a condition that I can manage and treat, but I know that there will be difficult moments. Since last September, there has not been a single day, not one hour, when I have not thought about either my blood sugar or the limitations that my condition may present. While I will not allow diabetes to define me, I know that I must be mindful that a chronic condition like diabetes demands 24/7 adherence to medical and dietary planning. Patients like
me need to be responsible for our own health; we need to pay attention to our bodies to optimize our wellbeing.

In the context of such an emotional turn of events, I was truly grateful for the opportunity to be in medical school and to become a physician who, like my endocrinologist, tends to the emotional and physical challenges of his patients. My experience as a patient reminded me of my power as a future physician. Beyond writing prescriptions and performing procedures, I will be able to support patients facing difficult diagnoses and to give them the tools they need to manage, if not overcome, their conditions.

With the perspective of a busy medical student who must manage a chronic disease, I will better relate to my patients who must adhere to new treatment plans while continuing with the rest of their lives. As a result of my personal experience, I can understand the shock of an emerging diagnosis, and I will be sensitive to the guidance my patients may need.

I hope to teach my patients that life is determined only 10% by what happens to us and 90% by what we make of it.
Living with the Inevitable

Prerana Chatty

About a year ago, I experienced what I now believe was my first physical (and emotional) breakdown. I was beginning my senior year of college and was in the thick of the medical school application process. I was not eating well, I never exercised, and I slept about 4-5 hours every night. Unable to process my stress, I first developed a severe pain in my left shoulder, then an abdominal pain, then severe headaches, so on and so forth. Failing to realize that my body’s breakdown was a result of my poor self-care, I fell victim to another demon – illness anxiety.

Many of us can identify with playing doctor on WebMD, but this was a heightened level of anxiety I had not experienced before. I visited doctor after doctor, all of whom told me I was in good health, but with each increasing visit, I grew more and more convinced that something was seriously wrong with me and that the doctors were not catching it. I was convinced that my neck pain was a neuropathy, that my abdominal pain was some kind of cancer, and that my headaches indicated a serious nervous system disorder. As illogical as that is, anxiety does not make sense – and as I quickly realized, learning about medicine does not make it any easier. While my symptoms eventually resolved themselves, and while I improved my self-care routine, the illness anxiety persisted. This physical breakdown had happened once, and in my mind, it could easily happen again.

I wondered if medical school would worsen my anxiety. I knew that medicine was the right career for me because of my love of clinical biology and my desire to impact others on a personal level, but I was worried that coping with illness all the time would be too emotionally difficult. In fact, I have found the opposite to be true.

The topic of death came up frequently during my first few weeks of medical school. Though heavy, it was an inevitable point of discussion. It was not until my professor, after calmly reminding us that “we are all dying the instant we’re born,” asked me if I was afraid of dying that I realized the answer was “no”.

I had to ask myself: if you’re not afraid of dying, what are you actually afraid of? What is it about illness that is so frightening if it’s not death? The answer was uncertainty.

Illness and death are uncomfortable topics of conversation. I feel this is because they reveal the lack of control and unpredictability that govern our lives. Illness and death make us feel powerless because they are all consuming, mysterious, and inevitable. I was, and am, truly afraid of a horrible and completely unexpected event taking control of my life.

I still struggle deeply with that fear – but in September, I took a huge step forward when a patient with Huntington’s disease and her family spoke to our medical school class about their experiences. Huntington’s disease is a highly progressive neurological disorder that one patient
has described as “having Alzheimer’s, Parkinson’s, and Bipolar diseases all wrapped up into one.” Patients experience cognitive and behavioral changes (which can be extremely difficult for the family to process), impulsive behavior, impaired psychomotor abilities, dysphagia (trouble swallowing), and progressively, dementia, and prolonged neurodegeneration.

While the presentation of Huntington’s disease varies in each patient, it is always severe and almost always fatal 15-20 years after the age of onset. The age of onset varies – it can be as early as 8 and as late as 60. Even worse, the disease is an autosomal dominant disorder, meaning that individuals with the disease have a 50% chance of passing it on to their children. This can lead to emotionally complex decisions regarding genetic testing when a patient is diagnosed with Huntington’s disease, especially if the patient presents with symptoms later in life. When a parent is diagnosed, for example, the family must make difficult decisions about whether the patient’s siblings and children should be tested. A diagnosis of Huntington’s disease is devastating, as we do not currently have a cure. The question arises: what is the benefit of knowing how you’re going to die? What would change if you could prepare for your death – what would you gain from your life?

The father of the patient that visited us (I’ll call her Ellen) died from Huntington’s disease. When she turned eighteen, Ellen made the difficult decision to be tested for the disease herself. Listening to her mother’s painful account of Ellen’s diagnosis was heart wrenching.

It forced me to ask myself: If you know you are going to die, how do you keep living?

That is exactly what is amazing about Ellen – she kept living. In an essay she wrote about her experiences since that diagnosis, she reminded us that she is living with Huntington’s disease and that she is determined to make as many happy memories as possible in spite of her illness. It is a form of strength I wish I could emulate and that I deeply respect. The love Ellen has for her family and her commitment to take the high road in spite of the knowledge of her terrible illness reminded me that the meaningful moments we create provide value in our lives.

Reflecting on my own anxiety, I realize that I cannot live with the fear of uncertainty. The harsh reality is that we are all going to die. Some of us are more fortunate than others, but we are all going to get sick. We do not know how or when, but if we live in fear of that reality, we do not live at all. If Ellen is able to live an incredible life in spite of her illness, we all can. Unpredictability is a truth that governs our lives – but that does not mean we have to succumb to it. I know I will still struggle with anxiety and my fear of the unknown, but I also know that I will think of Ellen and the importance of deriving as much joy from meaningful moments in my life as possible. We are all dying, but we are so fortunate that we get to live.

To this amazing patient and her family – thank you for helping me to see light in a situation that could be defined entirely by darkness. We live in moments and you created an incredible one for me.
Questions for Reflection

1. In “Medical Student’s Disease,” the author describes an instant where his medical school knowledge informed his experience as a patient. In “Type 1 for an M1,” the author describes an instant where his experience as a patient informed his medical school journey. How do you think your experiences in medicine outside of medical school will impact your experience in the classroom? What challenges do you anticipate in trying to relate your evolving medical understanding to your personal experiences in medicine?

2. In “Ventricular Fibrillation,” the author portrays EKG readings as symbols of a patient’s unique, individualized experience, highlighting the importance of humanism in medicine. How do you plan to keep your patients at the center of your studies? What unique roles do you think clinical objectivity and subjectivity play in medicine?

3. In “Living with the Inevitable,” the author describes how her improved self-care and increased self-reflection provided her with a sense of healing. What will be your strategies for maintaining wellness and self-care during medical school? What are some of the challenges you might face in obtaining help? Who in your life are you most likely to reach out to if you are struggling?
Patient Interactions

“The good physician treats the disease; the great physician treats the patient who has the disease.”

– William Osler
What You Will Know

Travis Quinoa

During one of my clinical observerships, I had the pleasure of interviewing an exceptionally sweet elderly woman, EM. She looked twenty years less than her stated age and her smile was complemented by her tan and rosy cheeks. EM was so funny and quick-witted that I found myself wondering if her hearing loss was just a facade she used to tune out of boring conversations. When I asked her to describe her recent bouts of dizziness, she kindly obliged and followed her description with a sharp and kind-hearted: “… but how much medicine do you know anyhow?”

I tried to keep up and quickly replied, “just enough to get me in trouble.”

In hindsight, I am not sure that my response was very comforting, but it was relatively honest and she laughed. I thought about that moment on my hourlong drive back to school. I kicked myself for not handling that part of the interview more professionally. I felt embarrassed by my reply, but I told myself that moment at least helped me build a rapport with Eleanor.

As I reflected more about my reply to her question, the veracity of what I said became more and more apparent. At that time of the year, about six months into medical school, we had already learned an incredible amount of material. I knew that while what we had learned certainly felt immense, it was hardly a fraction of what we will be expected to know when we are finally entrusted with the responsibility of caring for patients as physicians. Six months ago, if someone asked me what a “nare” was, I would probably have said that it sounded like a tropical bird. “Paresthesia” … well I’m not sure what that word might have sounded like to me – but I think we can all agree that “numb” rolls off the tongue a bit easier. I realized I was beginning to learn a new language and, with that, I spent the remainder of my ride home seriously contemplating, really for the first time, what I had learned.

It dawned on me that while listening to and interviewing patients at my physician-preceptor’s office, I was able to formulate a list of not-so-crazy-maybe-even-reasonable potential diagnoses. Reviewing a patient’s labs no longer meant staring at a computer screen and pretending to thoughtfully analyze a list of gibberish out of an insecure fear that the patient would somehow perceive my ignorance. I was at a point in my education where I could recognize a potential problem and, roughly, how to go about addressing it. I knew that a patient with primary hypertension might benefit from a drug like atenolol – but would I prescribe 50 mg or 500 mg? No clue. Nevertheless, my confidence was growing. I was learning. At this point, I liked to think that out of ten attempts at treating patients, I might not kill all of them. I was proud of the progress I had made. I supposed it was an honest reply, after all. I thought with a
smile – hearing EM’s laugh from my fresh memory of our interaction – “I know just enough medicine to get myself in trouble.”

EM had a serious problem. Even though it was never directly stated, it was clear that she was being treated for heart failure with a host of medications. Even though the doctor had taken her off of some medications two weeks prior, with the hope of raising her diastolic pressure, I got the same bottom number reading as the nurse at this visit: 38. She was still getting dizzy. Her vision would come and go and her at-home nurse had to catch her from falling several times. She let me listen to her slow heartbeat and a murmur that was so crisp and clear it ought to be recorded and used to teach medical students. I could tell she was nervous – and I knew just enough medicine to know she was in trouble.
His Story

Adiba Anam

I had been warned that Henry was a talker. This was further reinforced by the residents' knowing smiles, and the crack about seeing me again in about a decade or so. Henry's room was at the end of the corridor, right by a window. The sky was grey and unreadable and dark storm clouds shielded the hospital from the sun. Though it was early morning, there were very few people on the street. Everything seemed to move a bit slower that day, like a haze of sleepiness covered the city. It really was the perfect weather to listen to a story, or in this case, a history.

Seconds after I entered the room, Henry's loquaciousness became readily apparent to me. I had barely introduced myself to him and his wife before he began telling me his story. Henry was a 74-year-old male who was diagnosed with multiple myeloma. He had a tumor the size of a quarter sitting on his spine, which had recently been irradiated. Henry had been discharged from the hospital a week ago, post-radiation therapy, but had been readmitted due to difficulty eating and swallowing, which later resulted in dehydration, weakness, and fatigue. These were the relevant facts, the information that I was supposed to obtain and then leave. Promptly. I didn't want to leave just yet.

Henry spoke with his hands and his vibrant blue eyes; he was a captivating storyteller and I was already predisposed to being a willing audience. He spoke of his decades working in a shipyard, building colossal engines for even more colossal floating structures. He described his perpetual battle against multiple myeloma—a disease he seemed to vanquish, only to have it rear its ugly head amidst times of tranquility. Henry spoke of the immense purpose he felt he had—how in some way, the disease had given him special powers. I too was skeptical when I heard that bit and could not help but press for more details.

Henry told me that every person has a distinctive aura. The experience of his disease had given him the ability to see people in a different light. Literally. He told me that his powers were especially potent when he came across other cancer patients suffering from doubt and anxiety regarding their health. He said offering them unconditional love and solace brought him so much joy. Those moments allowed him to view himself outside of his body and see his aura mixing with theirs. I turned to glance at Henry's wife, a slender silver-haired woman who was as reserved as Henry was ebullient. She nodded and smiled softly, clearly accustomed to skepticism. Henry warned me of the contagious quality of auras. Something as meaningless as spilling coffee on my shirt in the morning could alter my aura. If I brought that frustration to a place like a hospital where people's auras are likely to be most vulnerable, I could inadvertently weaken others.

I have struggled with this concept of compartmentalization since beginning medical school. The first year is broken up into little compartments: Anatomy, Cardiopulmonology, GI,
Immunology, etc. Yet life hardly ever organizes itself in this way. Sometimes relationships end when you think they are just beginning to blossom. Sometimes people you care for deeply pass away before you can say what you need to say. Likewise, we can come across new life, love, and opportunity most unexpectedly. Even though our M1 blocks begin and end cleanly, the rest of our experiences blend in together, creating somewhat of a colorful mess. While there is humanity in the mess of life, I sometimes think our vocation calls for us to be more than human. Henry's story made me wonder if there is a way to harness our humanity, to contain the things we know could hurt others and instead, emanate all of our goodwill and positive intentions. Our positive intentions are always present and are at the heart of why we chose medicine. Over the course of day-to-day living, however, I think they often get mired in our own preoccupations, our own little (or perhaps big) messes.

I'm not sure how much I believe in Henry's powers or in his ability to see the color of a person's aura... or if I even believe people have auras, but I do believe in the contagiousness of unconditional positivity – something that Henry seemed to radiate freely. Perhaps Henry did see my aura and sensed what I needed. In sharing his story, he gave me something priceless: reassurance.
Breaking Barriers

Hersh Doshi

Being a patient-centered physician entails more than diagnosing patients and providing them with treatment options – patient-centered medicine requires working closely with patients to gather a comprehensive history, identifying treatment goals, and determining the best course of action. However, can this be accomplished if patients do not have adequate speech or motor skills to express themselves? I asked myself this question as my classmates and I entered a classroom at a school for children with multiple cognitive and/or motor disabilities in central New Jersey. We were eager to learn about the patient population at the school. The visit was an opportunity for us to put faces to many of the diseases we learned about in class.

In the first classroom, we met a group of 8-11 year olds with various disorders, including cerebral palsy, muscular dystrophy, and Tourette’s syndrome. Many of the children were confined to wheelchairs with headrests and neck braces for head support, straps across their bodies for safety, and mini-desks with pictures and phrases to aid with communication. The site director had warned us that many of the students were apprehensive of people in white coats because they associated doctors and hospital visits with pain. To help break their fear of doctors, the site director specifically asked us to wear our white coats. When we sat down with the students, many were distant and refused to acknowledge us. My earlier question crossed my mind again: how I would able to treat these students as a physician? Even when the students did acknowledge our presence, they were unable to express their thoughts and emotions. The question lingered in my mind as we began to play bingo. I sat alongside a student named Anabel. I helped her pick out bingo numbers, marked the correct square on her board, and tapped the “winning bell” when she finished her bingo board. After bingo, we played together and pretended to be racecar drivers driving through the streets of California. We had spent forty-five minutes together when, unexpectedly, Anabel began reaching for my face. As I got closer to her, she stroked my beard. At first, I thought this was simply a manifestation of her involuntary muscle movements. But she did it again. And again. And again. Her anxiety had evolved to curiosity. She had broken the barrier of the white coat.

Following this interaction, I thought about how the white coat barrier can impact even patients without cognitive and motor functional deficits. Clinical settings often harbor sentiments of fear and insecurity in patients, and patients are only likely to engage in an honest dialogue with their physicians if they feel comfortable and at ease. Trust enables doctors to understand a patient’s treatment goals, deepest fears, and personal dreams. For me, this trust manifested itself with the stroke of a beard in a classroom. The beauty of our Patient Centered Medicine course is that it provides students with the experiential resources to master the art of caregiving. The
ability to relate to and empathize with patients is as much a tenet of medicine as mastery of scientific knowledge, and if we do not prioritize both skillsets, we are doing our patients a disservice.

My interaction with Anabel, along with a mosaic of other patient encounters during my first year of medical school, helped me realize that connecting with others is a skill that requires a different approach from the regimented treatment protocols we learn about in class. Our first moments with a patient are crucial. It is difficult to relate deeply to a patient in just a 15-minute meeting. The challenges are steep, but we must play a role in breaking down the white coat barrier alongside our patients. Oftentimes, patients hold the solutions to their own challenges - we must work together to find them.
A Working Retirement

Amanda Eberhardt

It was a spring afternoon near the end of my first year of medical school, and I was shadowing Dr. S for the final time. Dr. S’s practice was always lively as patients with a wide range of medical concerns came and went amidst nurses and medical assistants bustling in and out of exam rooms. I glanced down the bright hallway and saw Dr. S’s next patient, Mr. J, joking with the nurse holding his chart. Mr. J’s jovial manner was infectious as he proceeded toward the exam room, greeting staff along the way. His warmth was apparent when Dr. S and I knocked and entered the room. Normally, I feel a bit nervous when I meet new patients, silently hoping they will accept my presence and remain patient with my imperfect (though improving) history-taking and examination skills. With twinkling eyes, Mr. J quickly put me at ease. He bemusedly handed me a “note” from his wife who could not make it to the appointment but wanted to be sure no details were forgotten. I smiled back and passed the note to Dr. S, who asked me to take the patient history and stepped out.

Alone in the room with Mr. J, I silently moved through the history taking steps in my mind. The reason for Mr. J’s easy going manner soon became apparent as he told me that he had just returned from a weeklong vacation to the Caribbean, and was heading south in two days on a golfing trip. He was enjoying every minute of his newfound retirement. It turned out, however, that the reason for his visit to the office was tied to his vacation. Mr. J had developed extreme swelling in his legs during his stay in Aruba. The shift in Mr. J’s mood as I examined his swollen legs was notable. For the first time, worry crossed his face. I wanted to put him at ease the way his kindness had reassured me just minutes earlier. I smiled encouragingly, but suspecting the seriousness of the situation, left the room quickly in search of Dr. S.

I presented the case to Dr. S, who did not appear surprised as he sat at his desk, the note from Mr. J’s wife beside him. At 6’2” and just over 300 lbs, Mr. J was struggling to maintain a healthy weight. He tried to exercise regularly but had gotten out of his routine since retiring, and had gained an estimated 10-15 pounds. He had a history of atrial fibrillation and had undergone two cardiac ablations in the past. He was also being treated for hypertension. Finally, I relayed to Dr. S that Mr. J believed he was pre-diabetic. Dr. S raised his eyebrows at this last bit of information and stood up from his desk. We re-entered the exam room to a wary Mr. J. The earlier jovial manner between doctor and patient changed as Dr. S almost sternly asked Mr. J if he had told me he was pre-diabetic. Mr. J now reluctantly admitted that he knew from prior visits that he had type 2 diabetes. It seemed to me, as the discussion continued, that the diagnosis of type 2 diabetes represented a turning point to Mr. J. In spite of his open attitude towards me, Mr. J had not wanted to face the diagnosis himself, let alone reveal it to a medical student.
Auscultation of Mr. J’s heart revealed what Dr. S believed to be atrial fibrillation, and an EKG was ordered. When Dr. S and I returned to the room, Mr. J seemed to be coming to terms with the seriousness of his present condition. I tried to comfort him, but wondered if he really needed time and space to grapple with this new reality. Dr. S explained to Mr. J that he was in atrial fibrillation again, and that he needed to address his edema right away. Dr. S prescribed a diuretic and wanted to see Mr. J back in the office in a week. This conflicted with the golf trip Mr. J had scheduled. As our discussion continued, Mr. J’s frustration with his inability to manage his medical conditions became apparent. He expressed that he had eagerly awaited his retirement to travel, eat, rest and fully embrace life. The exchange between Dr. S and Mr. J revealed to me Mr. J’s struggle to accept his chronic conditions and Dr. S’s struggle in facilitating acceptance. Running beneath the exchange was an evolving alliance between a reluctant patient and a concerned physician.

My interaction with Mr. J was the first time I had observed such a spectrum of emotions in a single patient. During the visit, Mr. J evolved from a happy go lucky retiree to a truly concerned patient. This was also the first time I myself experienced such a spectrum of emotions alongside a patient. Mr. J had effortlessly put me at ease, and I had wanted nothing more than to return this reassurance. Instead, I needed to provide him with the space to come to terms with his worsening condition. While Mr. J’s chronic health problems did not have quick solutions, there was still time for him to find an equilibrium between enjoying his retirement and managing his health. This would require motivation, commitment and above all, an honest dialogue between patient and physician.
How We Treat Patients

Erica Alexander

I arrived at the hospital at 8 AM on a Monday morning unsure of what to expect for the day. It was my first time shadowing and I anxiously waited for the residents to tell me where to meet them. I felt out of place in the large empty atrium. It was the same atrium where just months before I had walked across the stage beaming in my new white coat, excited to start my medical journey as my family watched proudly. It was hard to believe that this was the same room where I now stood awkwardly with no cheering crowd, wearing the same white coat that suddenly felt too big.

My wandering thoughts were interrupted when a woman visiting the hospital stopped and asked me for directions. I was unable to help her. I did not know where anything was; I did not belong there either. I watched as she glanced at my white coat, tried to hide her look of confusion and continued on her search for someone who could actually help.

Luckily for me, the residents finally told me where to meet them. I found them and stood waiting again, this time for the attending physician. When she arrived minutes later, she instantly drew the attention of the group. She asked us to introduce ourselves and then shifted her attention to the focus of the day - the patients.

The team was methodical. They efficiently presented their patients to the attending and she asked them questions about what might be wrong, what they should do, and she assessed their reasoning. I was amazed at how much the older medical students knew and wondered when, if ever, I would have all of this knowledge tucked away in the back of my brain.

However, my amazement was quickly tainted by an underlying feeling of disappointment. As I observed the interaction between the medical students, the residents, and the physicians, I was surprised by the disparity between their attitudes about the patients outside of the room and inside of it. Away from the patients, the team could almost be described as cold. Patients were referred to as “non-compliant”, “drug seekers,” and a “waste of time and resources”. One team member even commented that it would be “best” if one of the patients died before their airlift home.

As a bright-eyed medical student, I was astounded to hear physicians discussing patients with such little respect. I had been the recipient of wide smiles from physicians entering the room to examine me or entering the classroom to teach me how to practice patient centered medicine. I had rarely been exposed to the “behind the scenes” version of being a doctor that I was experiencing now. The derogatory terms used to describe the patients miraculously seemed to dissipate as the team entered the room. Smiles wide, eyes beaming, arms outstretched for introductions, the team entered the room, greeted the patients and listened to their concerns. The team gave their medical advice, scheduled tests, ordered medications and moved on to the next; leaving the patients seemingly more satisfied than before we entered.
I was conflicted as I finished rounds with the team. I felt that this was not a professional way to treat patients, but was it unethical if the words being uttered behind the scenes had no impact on the treatment or interactions with patients? At the same time, can this attitude about patients truly have minimal impact on the quality of care they receive? I wondered if the team’s rude comments about the patients were excused by their caring demeanor and their efforts at finding a treatment. Was it okay to speak in a derogatory manner about the patients just because they were not in the room?

I am still unsure of how I should respond to these comments. I wonder if my young age and inexperience make me naive because I have not spent time in the hospital, dealing with patients who come to the hospital, day after day, due to irrational fears or drug seeking behaviors. Or was this team in a particularly irritable mood that day? It is hard for me to say. I have kept this experience in the back of my mind, hoping that one day I will have the answers.

My experience that day taught me a great deal about clinical medicine, but I also learned how I did not want to treat my future patients. While I assume that one day I will feel as though I fit into my white coat, I also hope I will never outgrow it. I hope these initial feelings of excitement, optimism and insecurity stay with me even when I know the difference between atrial fibrillation and atrial flutter or can diagnose a patient before they’ve finished telling me their problems.

Sooner than I will be able to believe, it will be me rounding in the hospital, efficiently presenting patients to my attending, being expected to know the underlying pathology. With this wealth of information, I believe it is most important to continue to put patients first – to listen to their complaints, to hear their concerns, and to do my best to resolve them in a respectful and efficient manner.

The first time I stood on the atrium stage and shrugged my shoulders into my white coat was one of my proudest moments. I look forward to continuing to find ways to uphold the oath I took that day and motivate myself by helping others.
Two Moments

Akaash Mittal

At Rutgers Robert Wood Johnson Medical School, first year medical students are given the opportunity to visit community sites where they gain perspective on various patient populations. When I was assigned to visit a school for children with severe developmental challenges, I had little idea of just how significant my trip would be.

This school in central New Jersey supports children and adults who face severe developmental challenges. The students function at different physical and mental levels and the staff are well equipped to handle these wide-ranging conditions.

Stepping into the school is an incredible experience. It seems like sunshine radiates from every corner of the school from the security guard with a zest for life to the nurses who cherish the students as their own. For me, the school’s charm comes from its authenticity. In medical school, you are taught about the seemingly infinite pathways in the body, of which each and every one can be disrupted. These alterations are presented with etiologies, symptoms, and treatments, and are compartmentalized into charts and diagrams. This school gave them a face.

Once our group assembled in the school, we paired off and rotated through rooms in order to interact with students of differing ages. It was in the music room that I experienced the first of two moments that defined my time with these students. The room was a bright, vibrant space where students were given instruments to play (with the help of faculty) along with a performer. As a very energetic woman sang and played the guitar, my partner and I clapped along, and it was amazing to see the vivacity of the students after only the first few notes. At one point, the woman requested that we play along with a student, and next to me was a young girl who had very little control of her body movements. Initially, I was unsure of how this interaction would go, as I did not think that the girl would be willing to play with a stranger. Noticing my hesitation, the woman performing encouraged me to give it a try. As I slowly extended the drumstick towards the girl, she glanced at me briefly, as if to size me up. She then took the stick, and I guided our hands towards the drum, where for a few incredible seconds we beat it in harmony, moving together. Among the myriad of noises bouncing around the room, those few seconds were so intimate and peaceful that I simply wanted to sit there and play the drum for hours. Alas it was time to move on to the next room, where I experienced my second and more unexpected defining moment at the school.

Young adults sat in a circle in the middle of the classroom, and we took turns reading a story to them. It was a wonderfully interactive exercise, and I continued to feel appreciative of the opportunity I had been given. At some point during the story a young girl was wheeled into the room, lying on a stroller-like vehicle. My partner and I were asked to introduce ourselves,
and as I turned to the student, still beaming, my smile slowly faded away. Before me was a young Indian girl, probably no more than seven or eight years old. She had no outward physical abnormalities. She stared at me for what felt like an eternity, unable to change her expression. In those moments, it was as if we were alone in the room, unable to look away from each other. I was taken aback at how much this girl resembled so many I had seen before, even in my own family, and, retrospectively, I think the idea that this face of the school was of my own nationality startled me. I have seen a fair amount of patients as a student, but the truth is that I have not seen many Indian patients adorning a hospital gown. I think subconsciously this fact has helped to detach me from the patients I have interacted with. The reality of this girl’s physical condition struck me in an intensely personal way, and forced me to realize that the uncertainty of life impacts each and every one of us. Even now, I can visualize her expression vividly – solemn and unchanging with lowered eyes and a mouth seemingly sewn shut.

I believe that a pillar of medicine is the unknown, and that the adorning of a white coat signifies an acceptance of that unknown. The good news it that as a student you can not only traverse the unknown but also grow into it, and emerge stronger for having done so. The bad news is that a practicing physician will never truly escape uncertainty (but there’s always room for growth, right?). Sometimes the unknown will be wonderful, and create a bond you never thought possible, cultivated by something as simple as the beating of a drum. Sometimes the unknown will be uncomfortable and remove the rose-tinted glasses you so enjoy wearing. Everybody’s unknown is unique, unequivocally theirs to explore, and I thank these students and teachers for allowing me to experience some of mine.
DARE You to Listen

Patricia Berkanish

When I first learned I was going to teach a drug workshop to 14-17 year old girls, I conjured up images of generic D.A.R.E. workshops I had been subjected to as a teenager in suburban New Jersey. I imagined these girls to be much like myself at that age — someone who never seriously considered using drugs and had no access to them. I later learned that my pupils were actually recovering drug addicts.

I did not understand what the demographic of a recovering teenage drug addict really looked like. I could not quite reconcile the profiles of the bright-eyed young girls I had pictured with my somewhat stereotypical mental images of drug addicts. In my mind, teenage girls were innocent, healthy, spunky, moody, and opinionated. Meanwhile, drug addicts were strung out, aged, and out of touch. In articulating this, I now realize that it was incredibly close-minded of me to have thought that people fit into these neat categories. At the same time, I honestly had never been exposed to young drug addicts and had no idea what to expect.

When I arrived to teach my workshop, I found a group of young, smart, sensitive, and experienced girls. They taught me about the pressure of being a young adult in today’s society, which surprised me because I was a teenager not very long ago. I had so quickly forgotten how easy it is to be misguided when you are not quite sure who you are. I remembered some of the insecurities they described so acutely, yet in other ways I could not relate at all to my pupils. While these students emotionally and cognitively reminded me of a teenage version of myself, their experiences drastically differed from my own. Although I remember hearing crazy stories after the occasional house party during high school, those stories never involved couples trying ecstasy for a “bonding experience” like those the girls relayed to me.

Despite my understanding of the chemical impact of drugs on the brain, I had much to learn from my students. I explained how hallucinogens like LSD act on serotonin receptors in the prefrontal cortex of the brain, stimulating a region responsible for perceptions of reality, rationality, and communication. I told my students that this artificial stimulation can lead to feelings of an altered existence, colloquially known as a “trip.” In class this year, I learned about the teachback method, where physicians ask patients to teach them what they discussed during their appointment. This allows physicians to ensure they were understood correctly. When I asked one of my students to “teach back” what I had taught her, she responded anecdotally. Amanda recounted an instance when a friend in her foster home used LSD. Her friend was terrified as he was “coming down” from the trip and she simply sat with him until he fully recovered. The episode lasted nearly two days, but she remained patient, knowing that though this person barely resembled her friend, he truly needed her presence. I was so amazed by her
maturity in that situation. Though she did not know the mechanism of his hallucogenic state or the medical antidote, she so deeply intuited that he needed comfort through human contact more than anything else.

Amanda taught me the utility of companionship in recovery, and I hope that in my future practice, I can recount this just as easily as the appropriate pharmacology to treat my patients. In reflecting on this workshop, I have come to realize that much of my identity is defined by my family and the environment where I grew up. By good fortune, drug use was not prevalent in my neighborhood. By some twist of fate, I loved soccer, which prevented me from attending social outings that could have been unsupervised and maybe even dangerous. It now seems to me a miracle that my parents are happily married and that I am fortunate enough to have no idea what a foster home looks like.

I am glad that I was able to impart some knowledge about drug mechanisms and their side effects to these girls, but more importantly, I am humbled and grateful that they were willing to share their experiences with me. Most of all, I was reminded that people do not fit into categories as neatly as you might expect. I thought I had learned this lesson already, but this workshop reminded me of the importance of resisting stereotypes we have mentally created. Going forward, I hope to be more aware of how easy it is to make assumptions about people based on their age and upbringing, and of the importance of interacting with individuals of various backgrounds. There is so much to learn from patients’ and community members’ unique perspectives – we will never hear about them if we never ask.
It Doesn’t Just Click

Kristina Kelvy

One of my first visits to our family-oriented community health center was in November. I was rotating there for my assigned first-year offsite visit to work with a pediatric doctor during her Wednesday evening session. The major goal of these offsite placements is to introduce first-year medical students to taking histories, interacting with patients, and working with attending physicians and a health care team.

That is why I was there on a rainy cold November evening, still brain-battered from an anatomy exam two days prior, facing my pediatric patients’ parents that were looking to me for answers. No, they were looking to my white coat for answers. What was causing their daughter’s asthma to act up now? What could I do about a wound that wouldn’t heal on their child’s leg? What was the best way to get more vegetables into their children’s diets when they work most nights after working all day?

There must be a word out there for the overwhelming terror and excitement that comes with doing what you’ve wanted to do your entire life and having absolutely no idea how to do it. When I started medical school, I thought interacting with patients would be the easy part. I love talking to people and it is a privilege to hear their stories. However, in this moment, while I wanted to help the patients and their parents to the best of my ability, I had very few skills to work with. I only knew two-thirds of our anatomy course, I didn’t speak Spanish, the predominant language of my patients, and I had no sense of the factors that led to the progression of illness in these patients’ lives.

On that night in November, I had only potential. Some weird summation of all the pieces of my life led this medical school to take a chance on me. They believed I had the desire to improve my skills and that I just needed education and guidance to develop into a capable physician. It seemed like a long shot. Three months into this journey and I walked away from the clinic that night wondering when would it all click – when I would stop feeling so inadequate in the face of my patients’ questions and faltering under the expectations of my white coat.

Turns out, it really doesn’t click as I thought it would. I learned this on a sunny Saturday in April, as I walked out of the clinic after another pediatrics rotation. I followed my attending that day from room to room when she suddenly paused before knocking on the door of our fifth patient. “If our patient is okay with this, I’d like you to do the history.” Before I could respond, she knocked and entered. After a quick conversation, the patient’s mother agreed to speak with me first and we left the room. Back in the office, my attending handed me a guidelines sheet and the interpreter number should I need it. She gave me a few tips and sent me in.
I knocked and entered. I sat where my attending normally sat, smiled, and apologized for my shaky Spanish. The patient’s mother apologized for her shaky English. We began – and I learned. I learned about his recent emergency room visit for an ear infection. I learned he listens well to Mom and Dad, and that he has made friends at daycare. I learned that he might be the only kid I’ve ever met who likes broccoli more than chicken nuggets.

As I learned each additional facet of his story and their lives, I was checking boxes in the back of my head. Their community has fluoridated water; no multivitamin with fluoride needed. Check. He brushes his own teeth and dresses himself. He can identify colors and knows his name and age; shows good developmental progress. Check. He gets outside to play at daycare and has a couple hours of screen time a night. He likes riding his bike; make sure he knows how important it is to wear a helmet. Check.

When I ran out of questions and my guidelines sheet stopped giving me clues, I thanked them and told them I would return with my attending. Then, for the first time, I presented my patient. I highlighted everything I had mentally checked off, I raised questions about issues I was unsure about, and I gave my attending a list of talking points I thought were worth following up.

When I finished, she had one more question: “How confident are you in your history?” I asked her to clarify. “Can I base the rest of our visit off your work or would you like me to start fresh? It is okay either way, but if you feel the patient’s care would be better if I started over...”

I thought for a second. “No, we can proceed from here.” We continued the exam.

It took me twice as long to take the history than my attending took to take a history all day. The attending identified a few questions and follow-ups I missed – clearly, I wasn’t perfect. Things did not just click sometime in the four months from November to April, but on that day, I realized I had a few more skills than I did before. I had fewer feelings of inadequacy dressed in the shoulders of my white coat. I still have moments of overwhelming terror and excitement. Only now, when patients look to me and my white coat for answers, I realize how hard I am willing to work and how hard I have already been working to get those answers. I will not wake up one day and realize everything has clicked. I will wake up every day to realize the little bit of knowledge I gained each day before will accumulate and help someone new tomorrow.
Questions for Reflection

1. In “What You Will Know,” and “It Just Doesn’t Click,” the authors describe feelings of inadequacy and insecurity in clinical settings. Many medical students experience Imposter Syndrome, a sentiment marked by a failure to acknowledge one’s success and a fear of exposure as one who does not belong. What personal insecurities are you grappling with as you enter medical school? How might you address feelings of the Imposter Syndrome if and when you encounter them?

2. In “DARE You to Listen,” and “Two Moments,” the authors recount instances where their preconceived notions about certain patient populations where challenged, as they were forced to “become comfortable with the uncomfortable.” How do you work through situations that make you uncomfortable? Are there certain patient populations or clinical settings that make you uncomfortable? What strategies will you use to work through “the uncomfortable” in medical school?

3. In “How We Treat Patients,” the author describes behavior she observed in a clinical setting that deviated from her expectations of healthcare professionals. In your clinical observations, have you encountered disrespectful behavior? How did you address and process it? How will you address inconsistencies between your expectations of your superiors and your observations in medical school?

4. In “Breaking Barriers,” the author describes how he broke down the ‘white-coat’ barrier between himself and the student at the school. What role do you think trust plays in the doctor-patient interaction? Why do you think some patients develop a distrust of clinicians? How might you handle this distrust as a doctor?

5. In “A Working Retirement,” and “His Story,” the authors describe specific patient encounters that helped them develop a value of patient-centeredness. What do you hope to gain from your clinical visits during your first year of medical school? What does patient-centered medicine mean to you? What values and qualities do you think are most essential to becoming a patient-centered physician?
Conclusion

Those of us who instruct students in the skills and knowledge required to become physicians are privileged to serve as beacons and guides along what remains, in the end, an intense personal journey. The reflections contained in this reader are just a small window into the transformations and insights our students gain during their first year; many of the experiences which have a profound meaning for students are recorded only in their memories. They are stories of facing fear and death, the unknown, fantasies and misconceptions about doctoring, and as Dr. Terregino likes to say, “becoming comfortable with the uncomfortable.” They are also stories of achieving new knowledge, perspective, responsibility, and respect for the lives and circumstances of others who are not like themselves. Medicine, with ongoing scientific discoveries and technology, the ever-present pressures of time, corporatization, and coordination of care, still remains at its core one group of human beings attempting to help another. Discovering new solutions to deliver the best patient-centered care, while retaining humanity and resilience as providers are challenges facing the newest generation of medical students and practicing physicians alike. These writings remind us of the students we once were, and of the doctors we wished to become. In this way our students are as much a beacon for us as we hope to remain for them, and we appreciate their courage in sharing their stories.

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Appendix

Selected Medical Humanities/Narrative Medicine Websites and Journals

NYU School of Medicine – LITMED Literature, Arts, Medicine Database
http://medhum.med.nyu.edu/

Columbia University – Narrative Medicine
http://www.narrativemedicine.org/

Penn State University School of Medicine – Collection of Graphic Narratives
https://sites.psu.edu/graphicnarratives/

Arbor Vitae: The Arts and Literary Magazine of RWJMS
https://rwjmsliterarysociety.wordpress.com/

Rutgers NJMS - The Healthcare Foundation Center for Humanism and Medicine
http://njms.rutgers.edu/education/humanism/pe_lit_med.cfm

Pulse – Voices from the Heart of Medicine
https://pulsevoices.org/

in-Training: The Agora of the Medical Student Community - Poetry for Medical Students
http://in-training.org/poetry-medical-students-8090

Health Story Collaborative – Medical Student Voices
http://www.healthstorycollaborative.org/medical-student-voices.html

Stories in Medicine
https://storiesinmed.wordpress.com/

Intima – A Journal of Narrative Medicine
http://www.theintima.org/

Narrateur: Reflections on Caring
http://medicine.hofstra.edu/about/narrateur/index.html

Akesis
http://dune.une.edu/akesis/about.html

Bellevue Literary Review
http://blr.med.nyu.edu/

Journal of Medical Humanities
http://link.springer.com/journal/10912

British Medical Journal – Medical Humanities
http://mh.bmj.com/

KevinMD.com - Medical Journals That Accept Stories and Essays from Physicians
http://www.kevinmd.com/blog/2013/03/medical-journals-accept-stories-essays-physicians.html

Florida State University College of Medicine. Publish Your Work: Medical Humanities Journals