Stories from the great class of 2017, presented to the class of 2019 at the Transition Ceremony on April 29, 2017.

Special thank you to the Geisel School of Medicine chapter of the Gold Humanism Honor Society.

Cover design by: Natalie Y. Ring
Several years ago, Dan Lucey, DMS class of 1981, returned into my life. One of the great pleasures of a teacher is to see the paths of his/her former students and how much good they do in the world. Dan came to me with an idea...he wanted to glean from our alumni stories of wisdom from their lives in medicine post DMS, collect them and share them with current students who were embarking on their own journeys after their foundations were laid on the Hanover plain. What a great idea!

Around that time, President Hanlon was beginning his tenure at Dartmouth and in his first speech, he used the word "wisdom" too. He said that if a Dartmouth education was only bringing information and even knowledge to the participants, that that task could be done much more cheaply, efficiently and probably effectively in other ways. He said Dartmouth should be in the business of teaching about wisdom. That resonated with Dan and me and we were off to create this volume that we now give to you as a precious gift.

When he first came to speak to the medical school faculty, President Hanlon said one wish he had was that we could teach students about failure. Failure is such a ubiquitous part of life and the lessons from it (many of which are "wise" ones) are a tremendous opportunity for learning. It’s more about how one picks themselves up after a failure that is so important. These stories in this volume are not always about failure, but often about "a road less taken" that made all the difference when one had the courage to "go there".

You may ask "What is wisdom?" We hope you will recognize it by these stories that are told by the fourth years. Even more, we hope when it’s your turn as fourth years and as alumni to pass wisdom along, you will be generous with your insights.

One can tell a great deal about a culture by the stories that are told. We hope collecting and encouraging these stories will add to a wise Dartmouth culture at a time medicine needs much wisdom.

Joe O'Donnell, MD, DMS ’71
Dan Lucey, MD, DMS ’81
interaction with intention, sincerity and soul. You have made it this far in your training because you have proven to yourself and others that you can do just that. If you lead first with this, every wound you encounter on the wards will be graced by your light.

Erik Andrews

The first truly sick person I ever met was a 47-year-old devoted husband and father of four named Bert. Noticing a slow increase in fatigue, he went to his PCP, who was concerned with this history and ordered, among other things, a CBC and FOBT. Finding anemia and heme-positive stools, he scheduled Bert for a colonoscopy, which unfortunately found a mass in his right hemi-colon. A follow-up surgical excision with pathology confirmed the diagnosis of adenocarcinoma, and in conjunction with PET-CT, brought more dreaded news: the cancer had metastasized throughout his liver and into his lungs. Prognosis was grim: incurable, with an expected survival of 12-18 months.

Fortunately, Bert beat the odds and remained alive 18 months later. With a zest for life, he pursued all leads to beat back his disease while remaining focused on and positive for his family and friends. Traveling from Maine to Boston to NYC, he enrolled in 2 successive clinical trials, luckily receiving the experimental arms' (later proven superior) chemotherapeutics in both. Still, these newer carcinotoxic cocktails only slowed his disease’s toll, and by 29 months the downward trajectory was clear. At 31 months, surrounded by his wife and kids, he passed away.

You can probably tell that Bert was not a patient I met on the wards during a 3rd year clerkship. Instead, he was my dad. The experience of watching him take his last breath, and more importantly the 31 months leading up to it, was the seed that led me to medical school and the desire to fight disease. While long gone, I have frequently
thought back to him these past two clinical years as an intrinsic motivator, reminding me of why I’m here.

Why do I write about him for this story? Because I am sure that you also have a core, intrinsic motivation for going through medical school that I hope this story helps recall. And the advice I want to give is simple: whatever that force is, focus on it to sustain you, and avoid getting swept up in fixating on the extrinsic evaluations that frequently do nothing but demean that soul of why you are here. If anything, med school’s clinical years have perfected how to provide overbearing, external judgement whose frequent arbitrariness is only matched by its (perceived) weight. This will weigh on you...it certainly did on me. But I’ve come to realize that getting caught up in those judgements, and making your purpose to do well on them, demeans yourself. Nobody becomes a doctor in order to try and score well on evaluations and shelf exams. These are just cairns marking the trail up the mountain – important to reach and walk by, but not the reason for climbing. Resist slipping into becoming a cairn-seeker. Indeed, cairns are mere piles of rocks! The true value of it all is in being outside, of breathing in the air, of gaining strength with each stride...and in so doing, meeting and strengthening the lives of Berts along the way.

friendship we had built over the past month and I had the great privilege of being the last person he thanked before he passed away.

As you embark on this messy yet wonderful work of patient care, you will inevitably find that some patients stay with you. These are the patients that continue to inspire deep reflection in you and live on in their ability to continue teaching you through your care of other patients. Such was the nature of my relationship with Mr. M. The lesson I hope to share with you today is that the way we speak and engage with our patients matters. And these small-scale interactions we have with our patients, when carried out with love and respect, add up to something more than the sum of their parts. As was the case with Mr. M, these interactions seemed to him to matter even more than the traditional therapeutic armamentarium we offered, especially in the last days of his life. And I realized that taking the time to engage in meaningful patient communication with the fullness and openness of our hearts is often a far more potent therapeutic intervention than any tumor-specific small molecule inhibitor or targeted beam of palliative radiation therapy. Simply by taking on the work of drawing out the patient narratives that matter most to them, even a third year medical student can provide a dimension of patient care with unrivaled importance.

The poet Rumi wrote that “the wound is the place where the light enters you”. Despite what you may feel in the darkest hours of your clinical training, you actually do have the opportunity to be that light. Your light may not stem from data-driven knowledge at this stage in your career, but it can certainly originate in approaching each patient
some of the most valuable skills that can be brought to the art of healing.

Mr. M was a patient I helped take care of during an oncology rotation in my third year. He presented to the ED with back pain and a cough and was later found to have widely metastatic stage IV non-small cell lung cancer. As a non-English speaker in a clinical context short on translators, conversations regarding this patient’s values and treatment preferences were sparse, and it became clear to me during my daily pre-rounding conversations with him that he had expectations for recovery that were quite divergent from the natural history of cancer at this advanced stage. It also became clear that as the medical student on his case, I was spending far more time with this patient than any other member of the team, and that he was confiding things in me that he wasn’t electing to share with the team at large on rounds. With time, our morning interactions transcended the medical lexicon, and even though I didn’t feel equipped to communicate with him about the technical aspects of his care, we spoke about how important his family was to him, about his hope of seeing his 6-year-old son graduate from high school, and about all of the surprise romantic getaways he still had planned for he and his wife to take. We shared laughter at the jokes his son would recount to us, we shared optimism as he started to regain strength after his first cycle of chemotherapy, and we shared defeat as the subsequent scans showed progression of disease. In spite of the state of the art treatments he received over the course of his hospitalization, he died one week later, while still under my care. Counterbalancing the sadness and frustration he expressed about the inefficacy of our treatments, he expressed gratitude for the new

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Benjamin (Ben) Atkinson

As I have progressed through the earliest stages of my medical training, I have been supremely impressed by the depth of the medical field, and the many factors that contribute to making a clinician great. As a student, you often focus on the details of providing appropriate clinical care in the inpatient or outpatient environment. Mastering these basics is fundamental to becoming an excellent clinical practitioner, but scientific and academic mastery only provides a piece of the skillset that is needed to deliver excellent patient care. As I have watched seasoned clinicians during my 3rd and 4th year, I have been pushed to look more critically at the doctor-patient relationship, and the importance of developing interpersonal skills that allow for optimal patient relationships, and flowing from that, optimal patient care.

Though we spend time considering the doctor-patient relationship throughout medical school, much of the craft of patient interaction is developed through experience. Though I have progressed in my ability to build a relationship and rapport with my patients, I was struck by how much I had left to learn when I did an ICU rotation early in my 4th year. I was asked to participate in a family meeting for a man, Mr. H, who had been admitted to the ICU for sepsis and profound hypothermia, necessitating hemodynamic support and rewarming. Mr. H had cutaneous T-cell lymphoma, or Sezary syndrome, which had been refractory to treatment with multiple forms of chemotherapy. The severity of the cutaneous manifestations of his disease had led to recurrent bacteremia and numerous hospital readmissions over the course of
the previous few months. During this meeting, Mr. H’s wife and daughters were notified that there were no further options for treatment of his cancer, and that while treatment of his sepsis may lead to short term prolongation of life, it would be likely for him to continue to struggle with recurrent infections in his blood stream. Mr. H’s family was devastated. In a room filled with mostly strangers, they were receiving arguably the most heartbreaking news of their lives. They asked questions, they listened intently to what options they had, and most importantly, they discussed Mr. H and his priorities in life. After thoughtful discussion and many tears shed, Mr. H’s family decided to pursue comfort care, and he passed away later that afternoon.

I am still unpacking the emotions that I experienced that day, during that meeting. Muddled as they are, I can recall several feelings that have stuck with me since that gathering in the ICU conference room. First, I was impressed by the deftness and skill with which the clinicians answered questions and provided guidance to Mr. H’s family. Oncologist, intensivist, and palliative care physician all seemed to be able to understand the gravity of the clinical situation, and work with the family to reach a decision that was agreed upon by all. However, I was also struck by some degree of guilt. While I was involved in that meeting to help the family process such devastating news, I was also there to learn. In an odd way, I felt guilty for having someone else’s pain and misfortune serve as an educational tool for me. Still, looking back, I know that this is necessary. In order for me to become the most complete physician I can become, that type of learning experience is invaluable. I recognize that appeared around a corner in a wheelchair. “My beautiful, Sophia,*” he uttered with a combination of sincerity and relief. The tone of his voice made me feel like that they were reuniting after an eternity, despite only have been separated for 10 minutes.

One day, after speaking with her about worries surrounding her pending bone marrow biopsy results, she explained to me how much his presence during this admission meant to her. She went on to add, “I hope you find someone who loves you as much as he loves me.”

So yes, she may have been a “rock,” but she was also trying to navigate the unknown. Her words spoke to the kind of a deep, sacrificial love that can usher us through periods of uncertainty. The labels we use, even in jest, can minimize the patient experience. Our patients are more than a means to completing a checkbox. Treat them as such. Let them be your best teachers. They will broaden your understanding of the human – rather than the essential – condition[s].

*The patient’s name has been changed to protect her identity

Luca Valle

When you find yourself on the clinical wards, charged for the first time with the responsibility of managing the care of your patients, it can feel quite disorienting and you may find it challenging to know how to spend your time and how to be effective. I hope that the story below illustrates how despite the frustrations that go hand-in-hand with learning clinical medicine, you already have in your toolkit
cell lymphoma that had responded to chemotherapy roughly ten years ago. However, the CBCs obtained during this admission revealed abnormalities in all three of her cell lines, concerning for myelodysplastic syndrome (MDS). As her pneumonia resolved, she remained admitted as an inpatient awaiting the results of a bone marrow biopsy to confirm the diagnosis.

Since her “essential condition” was nearly resolved, I heard suggestions from my teammates to stop following her and to pick up another patient from whom I would learn “more.” By taking on other patients, I could check off more essential conditions. I have chosen to write about this patient because of the amount she taught me beyond her essential condition.

Indeed, the typical description of her medical history above failed to include key parts of her story. Namely, I learned the most from the love she shared with her husband.

He was at her side every moment of her admission. Hospital staffed arranged for a cot so that he could spend nights with her in her room. His daily questions during my pre-rounding revealed his degree of commitment to his wife and her health.

When he would ask to review her most recent chest x-rays, he gave me opportunities to practice not only my chest x-ray reading skills but also my patient-friendly communication.

When she needed to be transported down to IR for PICC placement, he wanted to join her. I will never forget the words he spoke to her as she

in order to treat patients and their families with the utmost respect, dignity and compassion, I must reflect on the skills that my teaching physicians utilized to navigate such difficult situations. It was a humbling experience, and as I enter into more of those situations during my intern year and beyond, I know I have much left to learn. Still, I am supremely thankful for the opportunity to have such a profound impact on people’s lives, and I will continue to work toward developing the skills that I can utilize to provide the most complete care to patients and their families.

**Kimberly (Kim) Betts**

One of the best parts about being a medical student is that you actually have time to talk to patients and get to know them. Though it may not seem as practical as taking a history, performing a physical, or writing notes, you’d be surprised how much you’ll learn from your patients when you pay them a social visit. Often, the information you learn from them will directly play a role in their management (such as finding out that they do not have a car, so perhaps you should send their discharge medications to the DH pharmacy instead). At the very least, however, you can learn something fascinating about each patient, and these are the stories that will stick with you and keep you motivated. To illustrate this, I’ll share a story I heard on my medicine clerkship, as told by a CPMC physician.

A number of years ago, an attending out in California was insistent that every patient had an amazing story to share. It was up to the medical
students to figure out what made each patient special; she would tell her students, “I don’t care if you skip the history and physical – I just want you to discover something amazing.” One day there was a patient who stumped the students; they couldn’t find anything particularly unique about this woman. The attending assumed the students just didn’t know what they were doing or how to “dig deep,” so she figured she’d “go show them how it was done.” To her surprise, she herself struggled to find anything unusual. Several days went by without much luck (maybe this was her first ever average, boring, run-of-the-mill patient?) until the day before discharge. Grasping at straws, she asked, “I see in your record that you broke your arm when you were 7. How did that happen?”

The patient responded, “Oh, that’s when the box fell on me.”

“Where was this box?” asked the attending.
“In the cabin.”
“What cabin?”
And the patient answered, “The cabin on the Titanic.” (As it turns out, she was one of the last living survivors of the Titanic!)

I love sharing this tale because it is a great example of how every patient – no matter how “normal” or “mundane” they may seem on the surface – has a story to unearth. You will likely face times where you are overwhelmed with the work that needs to be done, or feel pulled in many directions by your team’s requests and your studies. I would urge you to try to prioritize spending a few extra minutes each day with your patients to learn something special about them that you wouldn’t otherwise find in their medical chart. Indeed, these health, but the imperfect world in which we all find ourselves and which, as a result of our constant search for meaning, is evolving toward greater cohesion and solidarity. This process might bring us joy and will most certainly bring us greater peace of mind.

-The Wounded Healer, Canada College of Family Physicians 2008

I learned to recognize and stay in feelings, because they matter.

Marietta Smith

You will learn many new terms during third year. The term I want to teach you is “rock.”

Have you ever interacted with a rock in real life? If yes, you probably know that rocks are relatively stable and unchanging. Some rocks are also heavy and hard to move.

In inpatient vernacular, “rocks” are patients who remain on service for long periods of time because their condition is sick enough but relatively unchanged such that they cannot be moved to another service nor discharged. You may one day find yourself carrying a “rock” as a student. My “rock” was much more than her label would let you believe.

She was an elderly woman who had presented with signs and symptoms consistent with pneumonia. Pneumonia happened to be an essential condition on my Oasis checklist, so I picked her up. Her history included diffuse large B-
Klaudia, Heath, and Kathy. God bless them. And God bless the brave Dr. B. Trust and support within the team go a long way in feeling rejuvenated in medicine.

#3: Remember, doctors are human beings whose ability to authentically feel and connect is an important asset. Contrary to the stereotype, doctors do not lack for emotions. The medical student is too embarrassed to ask a patient to undress for a physical exam. The intern is sweating and cursing because the IV won’t go in on the seventh try and she hasn’t seen sunshine in three days. The resident is angry at the cocaine addict whose refusal of a CT scan will make him stay late again and miss, once again, putting his kids to bed. The attending is nervous on rounds because he’s a bit “rusty” with his inpatient skills and the residents might get wind of his ignorance. Emotions punctuate the speech and actions of all characters in this drama, but most doctors are not aware of the myriad levels of emotional resonance. It is both awkward and daunting to stop and wait. If we slow down and see where these feelings redound, we risk becoming too vulnerable. And so we talk and talk with a feverish clip to keep the reflective silence at bay.

-Danielle Ofri, Singular Intimacies

This better world is not some Utopia in which everyone is always kind and constantly in perfect

are the aspects of medicine that many of us find most rewarding and sustaining, and will reinforce our mission even in the most frustrating of times.

Christine Breuer

One of the most profound moments during my 3rd year of med school was during my IM clerkship at CPMC. On my first day, I was introduced to a 28-year-old female named ES with Guillain-Barre syndrome that had progressed to respiratory paralysis. Despite being fully conscious and alert, she could not speak and was on a ventilator. When I first met her, my mind was flooded with questions – how can I learn her history, how will I know how she is feeling or how much pain she is in, what questions does she have about her condition, is she scared?

Soon after, I remember meeting her mother – an exclusively-Spanish speaker from Colombia with red, weary eyes and a concerned look on her face. As the only person on the medical team who spoke Spanish, I was fortunate to get to know her and her family very well. I remember the relief we both felt when we met each other: for me, she was a portal to ES, and for her I was the portal to the physicians on her team.

We devised a system to communicate with ES using a written alphabet that we would scan through and ES would blink whenever it was the letter she wanted to use. We celebrated small communication successes but overall, progress was slow – her pain control was a continual struggle, daily neuro checks became progressively frustrating because of slow improvement, and the slowness of communication exacerbated all these frustrations for ES. The day I will never forget was the day ES had
a passy-Muir valve placed in her tracheostomy tube that allowed her to speak. With a group of six teary family members by her side, she was finally able to speak again. By this point in time, I felt like I was part of her family in a way – after all, I had been part of this major moment in their lives, cried with them, and even prayed with them at one point. Her first words to me with the help of her new passy-muir valve were “thank you, you are a beautiful angel that God sent for me.”

As I reflected on my time with ES, I thought, it is amazing that I felt so connected to someone who couldn’t communicate with words. In med school we’re taught to take good histories, use open-ended questions, and most importantly listen...but there is so much more to it. It is equally important to get to know the patient beyond their HPI or medical condition – learn their background, meet their family members if possible, and most importantly treat them like you would your own family. We are not always fortunate to have these opportunities with patients, but when they are there, take advantage. Medical students have a unique opportunity to get to know patients on these deeper levels. Those are the experiences that will stick with you.

Anne-Laure Dassier

Mr. Smith, Bob as he likes to be called, is a man of few words: stoic, always denying pain or discomfort, even as he sat across from us with severe anasarca and difficulty breathing at rest. His increasingly worried son brought him to the ED when he started complaining of difficulty urinating and severe edema in his genitals. For the past 60 years, Bob had avoided physicians, “Don’t see the

So, my question is about how to communicate these challenging topics, and not if.

Audience: So I would imagine that there were expectations that you had before transitioning and then realities you now live with. I was wondering if you could tell us a little about how they are different, and what you wish you had known back then.

Transwoman: I wish I had known how successful it can be.

I learned not to assume what the answers for your questions might be before you ask them. Staying open-minded has been an invitation to pleasant surprises.

#2: Agency will give you energy, and collaboration will boost it even more.

Dr. B being tied up somewhere in Presidio, I had to run a mini-clinic and see four patients on my own, delving into a world of stasis ulcer, somatic symptom disorder, AV fistula, and Hickman line evaluation. I cannot believe I was able to finish all encounters and come up with some assessments to relay to my attending. This was about the very first time I felt like I could pass as a future physician. That is a surreal feeling. Ten years ago, I’m pretty sure I was studying for AP Biology. Of course, I could not do this without help of the support staff,
aside not only history, but also his personal experiences during one of the most terrible atrocities of humankind, to get to know a random German medical student and encourage her. I learned three things. First, to never underestimate the value of “social rounds” during down-time – you will hear and learn the most fascinating things. Second, to always try and get to know the people around yourself and your patients - in as far as possible - even when your past experiences tempt you to put them in a “box”. It will be easier to show the “opiod seeker”, the “grumpy patient” or the “repeat ED admit” compassion if you know their story. Third, that encouragement is the most potent when it seems unwarranted. On the day you accidentally drop all your notes right before presenting, are blanking on your patients’ names, and things seem like an irreversible mess, believe in yourself and remember you’ll become a fine doctor.

Jihan Ryu
#1: Show up, face fear, and speak up. It is worth breaking the stigma of mental health, minority health, and self-care issues.

On Underdiagnoses: Let me think differently about communicating a suspect diagnosis directly to people suffering from domestic violence, substance abuse, and dysfunctional personality traits. Yes, it is a sensitive subject that requires significant building of rapport. Would I clearly communicate about the cancer that was found to a person, who thought it was just a minor stomach ache? Sure. Why would illnesses of mind be any different?

need for a doc” and only tolerated our current presence out of love and respect for his son. He was quickly diagnosed with Child-Pugh Class C cirrhosis. Eventually, he admitted to 59 years of significant drinking, with an average of 80 cans of beer per week. Many teams rounded on him: he underwent three paracenteses with a total removal of 18 liters of ascites and had an innumerable amount of tests and imaging done. This had a significant impact on Bob. He grew quieter, avoided eye contact and stopped making jokes. To make matters worst, a DIC scare sent him to the ICU where he met yet another team and received more attention, poking and prodding. This hospital course was stripping away his identity. I went to see him that same afternoon in the ICU.

We sat in silence for a minute and I decided to take a leap: “I can tell this experience has been very difficult”. “You think!” he replied. Remembering our on doc days, I continued, “We want as much as you do to get you back to your baseline. We want you to get back to the things you like doing. What do you usually do on Fridays?” He looked at me, wary of my intentions, and shared that he should be mowing the lawn with his son, which happens to be his favorite past time. After talking about the logistics of mowing 5 acres of land, we made a pact: as long as everything looked good, we would do everything possible to get him out by the next mowing date. For the first time in a week, he smiled. Our pact opened the door to conversations about his love for his family, his difficult times in the army, and use of alcohol to cope.
Bob reminded me of how dehumanizing medicine can be and how important as future physicians it is to maintain our patient’s dignity, wholeness and best interest at heart. I would have never expected that all he wanted to be able to do was mow the lawn with his son. A simple question about one’s routine day can lead you down the path of unexpected discussions of hardship, love, care and support.

Di Deng

One of the most precious skills (or maybe I should say wisdom) that are incorporated into our training here at Dartmouth is our ability to “listen.” By “listening”, I don’t mean just hearing the words that are pouring out from the person sitting across from you, but also feeling the emotions and the potentially “untold stories” behind the unsaid words. With that said, the wisdom I think that anyone can benefit from going into the clinical years is look at your patient and listen to her/his stories.

Mr. T is a Chinese Vietnamese man in his late 60s who preferred to speak with me in Mandarin Chinese, a refreshing diversion to my native language from the standard English of the hospital. He would show me pictures of food he made and tell me where to get a bowl of noodles that “taste like home.” A week into his hospitalization, he was diagnosed with endocarditis of both the mitral and aortic valves that had been repaired years earlier. Would he choose to go for the valve replacement surgery? The answer seemed obvious, but he was scared of all this: the sternotomy, the pulmonary edema that followed, Natalie Ring

During my internal medicine rotation as a third year medical student, an attending physician asked me to take a history from an elderly man with hip pain and delirium. As I spoke with him, the patient drifted through various stages of consciousness, straying from my medical queries to describe instances in his life when he had been beaten and urinated on. A little confused, but under time pressure to complete the observed interview, I did my best to gently redirect him. That is, until he finally showed me a tattoo of coarse blue numbers on his forearm and said “I was in Dachau for a while.”

After his admission to the hospital, somebody informed the Holocaust survivor that the medical student on his care-team was from Germany. Evidently it made an impression on him - despite his delirious state, he remembered this fact and from then on referred to me as “the German girl.” I was afraid my presence would make his hospital stay unbearable, and would have understood if he had asked for me to be removed from the case. However, he was never anything but incredibly kind to me. I would visit him in the afternoon while waiting for admissions, and as his hip and mental status improved, he spoke less about his experiences inside the labor camps and instead told me the most incredible stories about his life after escaping to the US. Before the gentleman’s discharge he exhorted me to continue working hard and encouraged me, without having any objective evidence or indication of the fact: “You’ll become a fine doctor one day.”

This was an instance of a patient teaching me about compassion and humanism. He was willing to put
money. You want to take my bladder from me too, don’t you! You want to give me your nasty drugs, take my life from me and take all my money while you’re at it! Just leave! Go do whatever it is you need to do.”

Dr. Seigne reached for his pager and without reading it, he handed it to me, “Can you please call whoever this is and tell them I cannot answer. I will return their call later.” As I left the room, Mr. S continued to yell. When I returned, Dr. Seigne was holding Mr. S’s hand and said softly, “Mr. S, this has been a long journey for you, and it is not over yet. Right now, this conversation is my only concern. Please tell me if you can, what can I do to help you?”

“I want someone to listen. I want someone to care. I know I might need to have my bladder removed. I realize now that I’m probably dying, I didn’t want to admit it. I am scared and I just want to know what to do now.”

All Mr. S needed was for someone to listen to him. Medicine is so busy, it is easy to rush through appointments and never actually listen to what patients want to tell you. A piece of advice moving into 3rd year: you have more time than your attendings and residents. Spend as much time as you can listening to patients and you will be amazed at what you discover. Your patients will appreciate it, and often you will be providing a therapy that patients are begging for inside.

and the rehab after his first open heart surgery that haunted him for years. “Do you think I should go for the surgery?” he asked me – a third year medical student. The responsibility and trust I felt at the time was enormous and humbling. I sat at his bedside, listened to all his concerns and explained to him what was happening to his heart and we contemplated his fear.

Medicine sees people at their most vulnerable. Perhaps what is needed most is simply: “I see that you are scared and I want you to know that you are not alone.” I believe that the best way to develop this trust starts with listening.

Jennifer Fleischer
Focus
Sometimes you get so focused
On the target and your goal
On ambitions and intentions
And fulfilling a set “role”

Sometimes you get so focused
On the science and “the fix”
You start to focus on diseases
Numbers, CBC’s, and lists

Sometimes you get so focused
Really “in the zone”
You are having a conversation
But its just with you alone

Sometimes you get so focused
You don’t see the forest from the trees
The human from the ailment
The patient from the disease

Sometimes you get so focused
On what you are trying to do
That you forget about the journey
And learning from that too

Sometimes you get so focused
You forget about the human race
- Just like there’s all kinds of people to treat
We need all sorts of doctors in this place

Sometimes you get so focused
Trying to fit into a mold
You forget about what makes you unique
And let your specialness unfold

Sometimes you get so focused
You forget that you are enough
That with compassion and understanding
You have all of the right stuff

Sometimes you need to remember
What it is you are trying to do
To focus on the journey
And bringing your best you

James (Jeff) Reeves

One morning during my first clerkship of 3rd year, I was in Urology clinic with Dr. John Seigne. Our last patient that morning was Mr. S, a 45 year old man with bladder cancer originally diagnosed 3 years prior at an outside institution. Mr. S had never received any treatment; his chart said he had “refused” surgery and “repeatedly refused” chemotherapy. Now, the cancer had spread to his spine and lungs.

As I entered the room, I saw a withered, emaciated man in a wheelchair, with unkempt hair and dirty clothes. He clutched belly in pain and appeared so exhausted I was afraid he would collapse. I asked questions I had learned to ask for a cancer work up. I quickly noticed that he was very frustrated and very angry – angry at his disease, but also at his previous doctors. I left to get Dr. Seigne and relay what I had learned.

We returned to the room, and Dr. Seigne probed for more details about his disease and past consultations. Mr. S told us how he was sick of being sick and sick of doctors. Three other physicians all said he was dying, but never listened to what he wanted. They wanted to give him chemotherapy. He wasn’t ready to die, but he also didn’t want their drugs. He had read about alternative treatments that weren’t as toxic, but nobody would believe him. He admitted that he didn’t trust doctors as they never have time for him.

As he told his story his frustration escalated. Dr. Seigne’s pager started beeping, and he erupted, “You know what, all you doctors are the same! You don’t care about me, you care about making...
Jeffrey (Jeff) Pedersen

One of the most important pieces of wisdom I received in my medical education came during my third year internal medicine clerkship at California-Pacific Medical Center. My first day on service I began taking care of a patient in her mid-50’s with HIV who was hospitalized for what we came to find out was CNS lymphoma. Throughout the two weeks that I worked with her, we had conversations not only about her health, but also about other things in her life that gave her meaning like her dogs and her motorcycle. On one particularly sunny day, she looked out of her window and saw a nice park several blocks from the hospital. She asked me if I had ever visited that park. I told her no, and explained that since I worked six days a week it was difficult for me to get out and do anything like that. She recommended that I make time to walk to this park. She said that she would love to go there but because of her health she clearly couldn’t. She went on to explain that if I allowed myself to be completely consumed by my work, opportunities to experience other parts of life would undoubtedly disappear. I decided to take her advice and walk to this park. It was a beautiful walk to a beautiful park. Moreover, it gave me time to reflect on what she had said. Medicine is a demanding profession, but I truly believe that we must be willing to make time to develop other parts of our life, be they family, friends, exercise, or other recreation. This will make us better doctors and more fulfilled individuals. In the words of Ferris Bueller, “life moves pretty fast; if you don’t stop and look around once in a while, you could miss it.”

Jennifer Fleischer

Resilience

You are telling me your story
All the things that you have done
The events you have experienced
The place where you come from

You are telling me your story
How you got where you are now
The ups and downs and twists and turns
- Sometimes you aren’t even sure how

You are telling me your story
And I see myself in you
I find myself starting to wonder
If that was me, what would I do?

“Walk a mile in my shoes” they say
“Trade places for a day”
How things could be so different
If I had grown up an alternate way

If I didn’t have the tools I have
My supports in friends and family
Access to schools and medicines
Or the genetic protectors conferred to me

If I faced those same stressors you’ve experienced
Or a trauma when I was young
Would I have the resilience to cope with them
Or would I simply be overcome?

You are telling me your story
And these thoughts swirl around my head
Humbled before you I sit
It could so easily be me in that chair instead
William (Liam) Guerin

I first met Cathie in the emergency department. “We’re admitting a 50 something female from ED 12,” the senior resident told me. “She’s got a big pleural effusion. Probably malignant, but she doesn’t know the CT results yet, so don’t talk about that. Just go see what history you can gather.” From the workroom to the emergency department, I prepared the history questions and relevant review of systems. Before knocking, I took a deep breath.

The room was dark. The breath was knocked out of me. A thin, pale, clammy woman lay on the bed in gown and blankets with her husband Tony’s hand atop her own. I didn’t need Cathie to tell me that she, in fact, did know about the masses discovered on the radiology study. With a set of unrehearsed questions, I learned that she had felt for months that something was wrong. I chased down the fan Cathie had requested over an hour ago. Over its noisy oscillations, Cathie and Tony explained the progression of fatigue and dyspnea, weight loss and night sweats, that lead up to this hospital visit. We talked until she was wheeled away for the insertion of a tube through her back to drain some of the stifling fluid.

After the next day’s surgical biopsy, I joined Tony in Cathie’s private room, which saw a quick parade of nurses and doctors. Her vital signs were worsening and the surgery intern called the resident called the attending. As the blood transfusion started, Tony began to weep in the far corner and all I could do was offer an embrace. After she was hurried off to the interventional radiologists for embolization of her hemorrhaging

At the time of my surgery rotation this role felt less important and less exciting than being in cases. Looking back, this is part of the process of being a member of the team.

One of the reasons I was hesitant to go into surgery in the first place was that I felt like I would be giving up the more social or humane aspects of medicine. After seeing Mrs. G. in the hospital I was reminded that spending a few extra minutes with my patients can go a long way. Spending a time listening to a patient isn’t specific to any field; it is how you manage your time and how important you make your patients feel. I visited her the next few days while she was in the hospital. Mrs. G. died 3 days after this admission at home surrounded by family. I remain grateful for her reminder that listening to patients is an important part of the team and ultimately a job for which students are uniquely suited.

Ultimately my words of wisdom include slow down and savor your moments with your patients. My favorite moments of medical school are when I stopped to enjoy the stories of my patients. This is how I learned to know my patients the best: to have ownership. In the end, this seems like simple advice. Take more time during your day to enjoy the moments because they are fleeting and pretty soon you too will be on the precipice of graduation writing advice to the next group of students.
Nicole (Nikki) Moraco

“You are my doctor.” She said while I breezed past on my sub-internship on my way to visit my final patient before afternoon rounds.

“Sorry, I am the medical student on another team. I am happy to find your intern if you need something.” I said this reflexively. Over the past year I have often been confused for someone who I felt like was more important more helpful than me.

“No, you were my doctor. You were my doctor at my last admission.” She replied with a smile.

It took me a minute to think back to the winter prior. She had been admitted to the surgical oncology service for a whipple procedure for pancreatic adenocarcinoma prior to my starting the rotation. She was still in the hospital recovering when I started my surgery rotation. I didn’t formally follow her, but she was on our team and as such I made morning and evening rounds on her every day for approximately 10 days before she went home. She was right, I was the student doctor on her last admission.

While on my surgery clerkship there were 2 students and a sub-intern. This meant that some days I would only have 1 or 2 surgeries in the morning and be free in the afternoon. When this was the case I would do the ‘scut work’, update the list or round on patients to make sure they were ‘tucked in’ before afternoon rounds. This often meant sitting at the foot of the bed of a patient like Mrs. G. listening to a story she had to share. Sometimes it was about her care; often it was just an excuse to chat when her family wasn’t available.

spleen, I sat with Tony, answering questions about what had just happened, until some friends arrived. They had intended to visit a recuperating Cathie, but found instead a bewildered husband, terrified that he might soon be a widower. At his wit’s end and with my crossed-heart promise of silence, Tony accepted the friends’ offering of bootlegged whiskey and tried to process how his wife had gone from driving their kids around two days ago to the brink of death.

I reviewed the suspected diagnosis to get ready to be “put in my place” – or PIMP’d – by my team. We rounded on Cathie daily as she stabilized and awaited biopsy results. Cathie was transferred to the hematology/oncology team after the official pathology confirmation. I visited to explain that I wouldn’t be seeing her in the mornings any longer. After some silence, Cathie broached a topic that put me in my place more than any attendings PIMP’ing. “I didn’t ask the cancer doctors about my prognosis. But I’m ready to talk with you about it. I just want to know, are we talking months or years?” I explained that it would be inappropriate for me to speculate and deferred to the oncologists’ expertise. Cathie pressed, “But I’m ready to hear from someone I trust.” From the ED through the complications, we had become connected. I felt comfortable sharing what the team had discussed about this kind of cancer’s prognosis in general terms and this sufficed for Cathie. I was honored by her expression of trust.

After moving floors, I tried to round socially after official work was finished. I observed her first dose of chemotherapy and its adverse effects. But I got busy, like we all do. A week or so later, a woman
called out my name in the parking lot of my favorite restaurant. It was one of the friends who had been in the room after the splenic bleed. She told me Cathie had been discharged and was feeling up to the rest of her treatment. About a month later, I got an email from Cathie:

*I have just completed my third chemo. You would not recognize me. I am thin, bald, but much stronger. You were instrumental in holding my hand through that first half. A sincere thank you for placing yourself there when you didn’t have to. I truly believe if I hadn’t gone through that extremely difficult time, I would have no idea the incredible rebounding I have done. A big hug to you.*

When the stress of reading, rounding, admitting, and hustling about the hospital builds up, I call up Cathie’s words. I try to keep in mind the power of taking an extra moment to hold someone’s hand. Sometimes your patient needs the comfort of a fan. Sometimes their spouse just needs a hug. They’ll know when they’re ready for the facts. Then you can rise to the occasion.

**Christina (Tina) Jaramillo**

**Listen to Empower**

It was a particularly overcast day as I sat upon the radiator in my patient Mr. C’s room, holding his hand as he silently sobbed. I am not sure what led Mr. C to share his story with me, perhaps it was the weather – abnormally gloomy for July – or his uneasiness towards his impending discharge. Regardless, I sat in silence processing his present the case to the attending physician with occasional interjections from the resident. Finally, the attending engages in a brief conversation with the patient to review either party’s unanswered questions and discuss the plan. The reset button is tapped and it starts all over again for the next patient. A great duck to train me, my attending in this story, had a different method.

We arrived in the ED, the patient’s name tickling my mind. The attending quickly recognized the patient as an elderly woman with a complex rheumatologic disease who we’d cared for a few weeks prior. He entered the room with the team and gave a hearty hello with a proper handshake and reintroductions. Rather than starting with the classic, “What brings you in today?” he began with questions I had not heard before, “Are you comfortable, dear? Warm enough? Would you like an extra blanket? Can we get you something to drink?” With her response he rose from his chair and left the room. I quickly followed him, trailing behind his abrupt departure, and in a moment we returned with a blanket and a beverage for our patient. She was grateful, after hours in the ED, to be warm with quenched thirst before beginning our conversation.
Vivienne Meljen
Be a Duck
“Be a duck,” became my mantra throughout medical school, so much so that my mother had it printed onto a canvas and has it hanging on a wall at home in my honor. As a medical student you might think I would be more interested in having the prowess of a lioness, the elegance of an eagle, the speed of a cheetah or the energy of a dolphin. A duck, as most envision it, does not have much appeal; except, however, when swimming. The quote that led me to emulate the duck is Michael Caine’s, “Be a duck, remain calm on the surface and paddle like the dickens underneath.” Just picture the creature, awkward as it may be, waddling alongside a pond, but once in the water, gliding on the surface. Submerge your view into the pond to see the intensity of its counter-current circulation powering those legs back and forth, propelling the duck forward. The act appears so different with this change of perspective. As a new third year student I “waddled” into my first rotation and after a few months, both patients and mentors complimented my glide.

On my medicine rotation during third year, my team was paged to the emergency department (ED) for an admission.

To give some context, as you may be new to this, oftentimes (in my limited experience) when the inpatient team is paged to the ED for an admission, the resident reviews a long checklist of questions in the electronic medical record while the medical student whizzes through history-taking. Only then do the two step out to have the medical student painful tale of addiction that resulted in his fourth admission. In that moment, I felt grateful that I had been granted the privilege of hearing the most intimate details of this man’s life; that I had the education that allowed me to understand addiction as a disease; and that I had personal and professional experiences that nurtured my patience, compassion, and humility. As my mind began to drift, Mr. C’s teary eye contact snapped me back into the moment. I searched for the words to offer support, understanding, and, most importantly, empowerment to change. My honest response amounted to, “I’m rooting for you.”

Throughout my first two years at Geisel, I (albeit, slowly) was able to gain a decent grasp on the pathophysiology behind the human body and disease. Yet, as my clinical years began, I realized that this offered only a superficial answer to the amorous question of “how do people heal” The more patients I encountered, the more real the many barriers to health became. Whether my team was on the phone trying to get a pre-authorization from insurance or trying to develop a stable discharge plan for a homeless patient, we were never focusing on merely the biological disease burden. Though I have always been an advocate for recognizing the social determinants of health, I soon realized that it isn’t enough to just consider them. Whether you’re like me and going into a field known for evaluating the “big picture” or not- who the patient is outside of the walls of the hospital must purposefully underlie every decision you make.
If you can’t imagine this being difficult, I can guarantee you that some days it will be. I watched many of my very capable and compassionate superiors walk into Mr. C’s room, only to walk out condemning him to being “just another alcoholic” while quickly citing which tests and orders needed to be put in to stabilize and discharge him. It’s not easy to look deeper while still keeping up with your endless clinical responsibilities. Yet, when I took my (much more abundant) time to hear Mr. C’s story of abandonment and loss, it became so much easier to see him for who he was—a kind man in the throws of disease due to a lifetime of pain. By genuinely caring about him as an individual, it opened the door to so much more trust and receptiveness to difficult conversations between Mr. C and his entire care team. Finally, on this fourth admission, his course seemed to be following a new trajectory despite the same routine labs, tests, and evaluations.

Mr. C exemplified to me how much of a disservice we do to patients by not hearing their stories or “big pictures”. While stabilization of the acute issue is undeniable important, at the end of the day we are fooling ourselves if we think we are any of our patients’ saviors. Our primary job should be to listen to our patients’ stories of overwhelming disarray in hopes of helping them regain control. This won’t always be easy, but I really believe more often than not it will be worth it. After all, I have found the most gratifying experiences are not just helping patients but rather empowering patients to help themselves. Mr. C could not have said it better when we said goodbye the next day before his third

Kind to yourself
when you can no longer stay awake and read that textbook
Kind to your patients
when that last patient of the day is keeping you from a dinner with friends you have not seen in months
Kind to your residents
who are so overworked they forget to give you a chance to deliver that patient presentation you have been practicing all night
Kind to your attendings
who decide to teach despite a plethora of non-clinical pressures that you (thankfully) don’t yet understand
Kind to your roommates
who make that cold Lebanon, NH apartment a home
Kind to your family
who remind you of all the other wonderful parts of yourself that you might not get to share in the busy walls of the hospital
Kind to the underclassman
whose questions will inspire you and remind you that every day you get just a little bit better maybe even wiser
Kind to the support staff
who are often the first face our patients will see

Kindness is gentle, patient and somewhat understated yet it can be so powerfully rewarding to those who give and receive it.
I remember sitting with him late in the evening in an over-bright exam room, holding his hand while the radiologists drained the worst of the fluid from his abdomen. I remember innumerable conferences with his wife and son and sister-in-law—in the hallway, in the family room, at the bedside. I remember his wife laughing and calling me her “Kleenex angel” for all the times I’d fetched her tissues. I remember perching on his bed hours before he died, looking into his blank eyes while I auscultated his frantic heartbeat.

My memory of P does not wrap into a neat morality tale—I can’t seem to communicate what, exactly, I will take from my time with him. But I know that I will never forget his smile, his gentle humor, his wife’s dignity. I will never forget how, when his wife knew he was dying, she wanted to keep P in the hospital with our team because she trusted us to care for him in his final moments. That seems to me to be a sacred trust, the sort of thing I entered medical school to learn to do.

Chengetai (Chenge) Mahomva

Kindness

I don’t have a wisdom story to share but I do want to make a plea to always choose to be kind. The third year of medical school is exhilarating, your days will be filled with wonder and your life will take on a purpose few have ever imagined. With all these highs come unexpectedly difficult lows, a yearning to be as efficient as possible and rush onto the next shelf exam, clerkship or site. I just ask that you please take a moment and remember to be kind.

Kristen Jogerst

I do not have one particular moment from clinical clerkships to share with you. There was not one pivotal moment that can give you a glimpse into the world you’re about to begin. Rather, I would like to share a helpful reminder with you that helped me during my lowest moments of third year. Yes, this is an exciting time. You should be appropriately excited to begin this privileged journey of third and fourth year of medical school. It is going to be a very impactful two years, or at least it was for me. This could be the only time in your life where, one month, you are delivering new life into the world, and the next, sitting with a family as you explain a terminal diagnosis alongside the critical care team and Palliative Care. One day you will be playing with toddlers as you assess their growth and development, and the next, you will remove a patient’s skull to literally peer into their mind. Patients will entrust you with a lot: their health, their stories, and sometimes, secrets they have never told anyone else. Perhaps, more so now than at the white coat ceremony, you will start to feel the true weight of your coat and your stethoscope and your ability to listen to patients: not only auscultating their hearts, but also their souls. And with this privilege, this weight, there will come a lot of pressure. Pressure to perform on rounds, in the OR, and during didactics. Pressure to help patients when they’re not yet ready to receive that help. Pressure to make the most of every minute in the evening, preparing for the next day’s stint in inpatient rehab, “Thank you for listening. I’m rooting for myself now, too.”
rounds, surgical cases, and sometimes hardest of all, the shelf exams.

However, this pressure is not without reward. You will grow and change: as a physician and a person. You will hone new clinical diagnostic knowledge, procedural dexterity, and patient communication skills. Your view of the world and yourself might change – several times. You may be afraid you and your classmates will change too much. I hope your change is a positive progression along the physician-training road plan you initially developed when you altruistically delayed other life plans to apply to medical school. It is important to not forget those altruistic goals. Others might become competitive; let them. Others might try to throw colleagues under the bus to improve their status on rounds; please do not follow suit. Others might abandon their original goals; I hope you won’t.

When it reaches the 24th hour of your 28-hour call shift, when you are not quite sure you can help with another admit, another long surgical procedure, or balance stressed patients’ families and your overworked team: I urge you to do what I did. Go to a bathroom. Splash some water in your face. And look yourself in the mirror and say the following: “You are a nice person. And you’re going to go be nice to people, because that is what you do.”

I received this helpful advice before starting my third year clerkships and rolled my eyes at the idea. Perhaps, you are rolling your eyes as you read this. I never thought I would hit the moment when I would need a direct and concrete mantra to stay true to who I am. But I did. And perhaps during third or fourth year, you will too.

A wise surgeon once told me: “The edge of your comfort zone while learning to operate? That’s where the magic starts to happen.” Third and fourth year can be tough, but if you stay true to yourself, if you remain the nice person I know you are, I promise it can also be magical.

Megan Rose Laporte

I remember dozens and dozens of patients from my time on the wards—the gruff but tender-hearted man with a stubborn fever of unknown origin, the anxious mother of two wrestling with end-stage breast cancer, the elderly lady who had suffered a hemiplegic stroke and was ready to die. The patient who I suspect will stay with me the longest was our Scientologist with a lovely family and a terrible esophageal cancer.

We admitted P from the emergency department with the worst edema I’d ever seen—each of his thighs was nearly as large as his ribcage, and he could barely talk for the fluid in his lungs. He’d been pursuing an alternative medicine regimen in lieu of chemotherapy, and had deteriorated quickly since his diagnosis nine months prior to his admission with us. Despite all of this, he and his family were unfailingly polite and charming. His wife brought in blueberry shakes for him every day, chatted with other patients, and advocated for her husband with gentle but firm resolve.