



STETHOS



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Cleveland Clinic Lerner College of Medicine
of Case Western Reserve University

2019





Passage of Time
 Alice Tzeng | CCLCM Class of 2021



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Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

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Front Cover Artwork

I Look Like a Surgeon: CCLCM Edition
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 CCLCM Class of 2019

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J. Harry Isaacson

Professor of Medicine & Executive Dean
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CCLCM has reflection as a core value, embedded in our competencies and assessment system. Reading the 2019 *Stethos* issue led me to reflect on this past year. 2019 has been a year of change. As you read this, CCLCM will have relocated to the new Health Education Campus (HEC), a spectacular building representing a unique partnership between Cleveland Clinic and Case Western Reserve University. The HEC will allow sharing of space and foster collaboration between the two CWRU medical school programs (College and University programs), the CWRU Physician Assistant program, and the CWRU Nursing and Dental schools. In the HEC, CCLCM will maintain its unique identity while also helping lead an interprofessional education effort to better prepare health care students to work in teams.

There have been other changes. In the last year, we have seen the transition out of leadership roles of three of the most influential members of our CCLCM family: Deans Kathy Franco, Alan Hull, and Jim Young. Each in their own way helped shape CCLCM and enabled it to grow and evolve into something better. Fortunately, they all continue to be involved—Dr. Young as the Chief Academic Officer at Cleveland Clinic, and Drs. Franco and Hull as part of our retired emeritus faculty.

We are grateful for the integration of the medical humanities into the CCLCM curriculum, championed by Dr. Young. *Stethos* has developed as a jewel in our humanities offerings, a wonderful outlet for reflection on

our experiences as health care professionals. The 2019 issue of *Stethos* continues in this tradition and offers a rich palette of humanities offerings including photography, original art, poetry, and prose. Submissions come from not only CCLCM students but also nurses, undergraduate students, and faculty. Reading Dr. Franco's reflections in "CCLCM Since 2002" was a trip down memory lane. Dr. Franco highlights many events over the past 17 years and concludes that we continuously improve one targeted area for improvement (TAFI) at a time. Who would have known in 2002 that TAFI would spread to every corner of CCLCM as a symbol of our commitment to continuous improvement. TAFI is part of our lexicon!

Stethos 2019 offers stories of first experiences; stories and poems that reflect the struggle to process our reactions to patients and illness; reflections on topics as diverse as mindfulness and flyfishing; photos that remind of us of the beauty in our world when we look closely; and art representing a spectrum from an adaptation of a classical work from the 1800's to themes from modern health care. There are personal stories that show the courage to be vulnerable and anonymous pieces so raw that the authors preferred not to attach their names. It's all there in this issue. I hope you enjoy *Stethos* 2019 as much as I did. A special thanks to the editors-in-chief Kaitlin Keenan and Alice Tzeng, and to their dedicated co-editors. In *Stethos* you have created something special that is part of the fabric of CCLCM. Congratulations to all on *Stethos* 2019.

Dear Reader,

Thank you for choosing *Stethos*! We hope this issue will inspire as well as educate you. Inside, you will find reflective narratives, poems, photos, art, and essays. While the subject matter is broad, we the Editors noticed that a major theme this year is growth. Some stories are cheerful and humorous; others are more raw and somber. Wherever this issue finds you, we want you to know that you are not alone. *Stethos* is just one of many threads connecting our students, faculty, staff, and other health professionals in the greater tapestry of the Cleveland Clinic.

The CCLCM community has experienced many changes this year, and the majority of our submissions reflect these experiences. Dr. Kathleen Franco, who has been an integral part of our community since the beginning, is transitioning out of her role as Dean of Student Affairs and Admissions. We would like to dedicate this issue to her, as she has always been a champion of the medical humanities. Dr. Franco taught us to embrace a growth mindset, to listen to our inner voices, and to protect time for creative pursuits. Not only did she encourage us students to develop these practice patterns, but she also

demonstrated them herself. In this issue, you will find two pieces she wrote: one celebrating the past and another contemplating the future. For those who are less familiar with CCLCM history, these pieces will be educational as well as inspiring. While the Dr. Franco chapter of CCLCM is coming to an end, we are thrilled that Dr. Christine Warren, a CCLCM alumna, will be taking over. As we look forward to the next stage of CCLCM evolution, the Editors would like to remind our readers and writers that *Stethos* will continue to bring us together. We hope that our next issue will include even more diversity—highlighting the importance of all caregivers in the medical world and uniting people of different backgrounds under our shared love of the medical humanities.

Enjoy! We will see you next year!
The Editors

Although well known for established programs in continuing and residency education, the Cleveland Clinic had long wanted to foster a third branch of physician education: medical student education. The fourth year elective program was established in the 80's and was hugely successful, with students coming from all over the world. But it wasn't enough. In 1992, the Clinic and The Ohio State University formed an academic partnership that included medical student education and biomedical engineering. However, the Clinic wanted more autonomy to build a program unique to its strengths. Faculty met and decided what they wanted in a program and in prospective students, determining that translational research was one of the Clinic's unique primary attributes. Faculty members were also very interested in implementing problem-based learning, small group learning, and the competencies established in residency education. The ideal medical students would be passionate about research, possess strong interpersonal skills, be team players, and exhibit self-direction and reflection. How was the Clinic to do this?

There was great excitement in the year 2002 when it was announced that the Cleveland Clinic and Case Western Reserve University would collaborate on a new program. Faculty from CC and CWRU joined in President Ed Hundert's home for a reception and celebration. Dr. Hundert and Dr. Floyd Loop stood on a tiny landing at the base of the stairwell and together talked to us about the amazing future ahead. They acknowledged that there had been animosity since Dr. George Crile and colleagues started the Cleveland Clinic so many years ago (Dr. Crile was no longer allowed to practice in Lakeside Hospital). They expected all of us to join hands and make sure the new venture succeeded. They joked about playing in the sandbox together and affirmed that we would make each other stronger. It's funny to recall the comments from that evening. Some of my Clinic friends feared that CWRU would not let us become faculty members, aware that they had not brought Dr. Bernadine Healy into the fold. One CWRU friend said she and her colleagues were worried that they would have to work as hard as we did on the Clinic side. It all seems humorous now knowing that we are so much closer together. There was some grieving among Ohio State University graduates working at the Clinic: the nearly 10-year-old relationship had been dissolved, and to them that was all loss. As for the rest of us, we looked forward to having our own program encompassing all years (not just three), with the ability to carry out problem-based learning and research. Dr. Loop had been talking about having our own program for some years. Initially he envisioned a clinical track, a research/clinical track, and a business/clinical track. Over time and with some reality testing, the curriculum that developed was one that integrated research with clinical experience from the onset.

How many committees do you think were working on the curriculum? (12, 19, or 24?) 19, with more subcommittees. The first LCME letters would reflect this.

Opportunities to participate in many planning committees arose from all directions. One or two CWRU faculty sat on these committees to give guidance based on their experience, which helped us get through the LCME so that we could even begin to function. There were committees for basic science, clinical education, foundations for medicine, communications, curriculum oversight, and many more. I can recall being on 7 committees at one point, which was definitely beyond my capacity, before cutting back.

Many of these committees met every week in the evening, and some convened on Saturday mornings. My husband could count on my being home late almost every weekday. It was a demanding two-year preparation, but well worth the extra effort. We really got to know people across the enterprise that we had never met. Basic scientists mingled with clinicians they had not known existed. Though there was a lot of writing to be done between committee sessions, when the committees came together, the excitement was palpable. Every few

months there would be a larger gathering during which multiple committees would join together and present their progress since the last event. Dr. Lindsey Henson, who worked under Dean Horwitz at CWRU, ran between committees to connect loose threads. We were also blessed to have many faculty from CWRU attend our various committee meetings and provide suggestions from their experience. The charge for CCLCM was to create our dream school: "Make this the school you wish you had attended". I often joked this made us as happy as "pigs in mud". Everyone wanted to comment on what they had liked (and disliked) about their medical school. We had amazing visions of blending basic science teaching into the clinical setting. We also envisioned faculty learning from students as much as students learned from faculty. There were bumps along the road, with some disciplines believing they deserved more teaching time than others. Those meetings could be raucous, but for the most part everyone only wanted what was best for the students—it was just that there were differences in opinion about what the "best" involved.

How many applications do you think we had the first year? (608, 710, or 949?) Liz would know.

Dr. Jeff Hutzler screened the first set of applications, and we began to interview. It was so much fun to select our own students and try to imagine which ones would best handle being pioneers. Many of us had written problem-based learning cases from our patients and practiced with the CWRU students doing clinical clerkships at the Cleveland Clinic. I remember another faculty member trying to insert child abuse into a patient case I'd written. Although I recognized we should be teaching about child abuse, it didn't fit into that particular case since it had not occurred in my patient's life! Fortunately, the CWRU students intuitively knew that detail didn't belong and asked to have it removed. I began to have even more confidence in problem-based learning. We also had to test our interactive seminars with our committee colleagues; if they felt the seminars were not interactive enough, it was back to the drawing board. A new and improved version would then return to the committee for evaluation. It was really so much fun—almost like being back in medical school without the stress of tests and grades. Dr. Andy Fishleder was the capable executive dean, guiding us in our growth and the process of working in harmony with CWRU. Drs. Loop and Fishleder were instrumental in working with Al and Norma Lerner to bring this vision to life.

There were bumps and bruises early on, with problem areas that had to be corrected. One student was not able to adapt to the learning process. There was a CEO change that transiently split the class. Deans were coming (Franco) and going (Hutzler and Henson), but as we moved into the second year, things began to move smoothly until the students realized they were going to have to take Step 1. The CCLCM program was based on competencies, and there were and are no grades. We were forbidden to teach to the test, and there was no preparation course available. Nonetheless, the first class all passed, and we were able to breathe, recognizing that we had passed another developmental milestone. Now we had to try out the blended blocks of clinical rotations. These blocks were longer than the current ones and allowed for very little flexibility. Students were constantly rushing in and out of the office, worried about surviving Surgery or some other rotation. After they completed those core rotations, we could take another breath and appreciate another developmental milestone and what TAFIs (targeted areas for improvement) needed to be addressed. To be honest, some days it felt like we were only 2 or 3 steps ahead of the students. Aside from the anxiety felt by both students and faculty, there was more energy in the air than I had ever experienced in my life. Faculty had volunteered to participate in the College and reveled in the work. The joy of learning and unending curiosity abounded in any direction you looked. However, more hurdles arose as the students entered the research year. They had to very quickly figure out how to find a mentor, get the projects approved (not only by the Research Education Committee but also by the IRB), and search for funding.

The projects were completed not long after Wilma Doyle and I had attended an AAMC conference on how to help students apply for residency, yet another developmental milestone. Not only was that time coming upon us, but also we were ready to take a fifth class. Fortunately, Dr. Richard Prayson agreed to join our small Student Affairs troop and push through Year 5. All along, Liz Myers, with diverse individuals assisting her, managed the finances, admissions, and recruitment for an equally diverse class. It seemed like we were juggling many balls—perhaps so many we couldn't count them all—but students seemed to survive and actually thrive. One of the compliments that students consistently gave is that the faculty were very open to suggested changes.

One amazing day in 2007, just as we were finalizing the new class, Dr. Toby Cosgrove asked all the students and faculty to come for a special announcement. That had never occurred before, and there was more than a little anxiety in the air. The big surprise was that every student would receive a full scholarship, and those who had paid tuition would be given back some of that money. You can't imagine the joy and celebration that followed. Dr. Loop had talked about this possibility when establishing the school, but the farther we marched on from those early days, the less likely it seemed. Dr. Cosgrove had made it happen! We were in shock and amazement all at the same time.

In total, how many yearlong grants do you think have been awarded to CCLCM students? See Annual Report.

Over the years, the admissions process changed greatly to allow us to select students who would enjoy learning in our unique environment. One applicant termed us the Montessori of medical schools, and that descriptor was quickly picked up by Dr. James Young, who took over for Dr. Fishleder in the middle of the 2008-2009 academic year. Research was thriving! The first NIH grant won by a CCLCM student was in 2006; the next year, the CCLCM class was awarded two grants; and the number has only grown since then.

Threads became more identifiable during the basic science years, and clinical rotations went through various alterations, incorporating most recently the Longitudinal Ambulatory Block. Upperclass students taught the younger students communication skills as well as how to study for Step 1, survive particular clerkships, and find a research mentor. They also shared how to study for later board exams and apply for residency programs. We needed the older siblings to teach the younger siblings, as we were all learning at the same time. This was part of the joy and glue that brought the family together. There were growing pains of course—the first year, we only had 11 women and one student from a diverse background. Clearly, there was a lot of work to be done. When the first class took Step 1, the class below prepared the first survival boxes. The third class forgot (oops)!! We never let that happen again. The students initiated a buddy system and kept it alive, with current students working to strengthen the program.

Orientation, the White Coat Ceremony, Match Day, and Graduation come faster and faster in sequence. For those of us who have been here many years, it is always sad to see the seniors leave. We try to remind ourselves that birds must fly from the nest. There are a lot of patients for them to see in their future years and many exciting research advances for them to make that will help millions. This knowledge makes the pain easier. It is impossible to describe the beautiful ripples that have come from CCLCM—the inspirational physicians, leaders, and scientists—and can you believe they come out filling all of those roles at once? All of the CCLCM faculty, alumni, and students to come are joined in celebrating who we are and who we will continue to be. Each of us is improving one little TAFI at a time. We can be proud of our CCLCM family!



Dawn

Wenda Ye | CCLCM Class of 2020

The Curiosity Conduit: Lessons from My First Patient Encounter

Aiman Faruqi | CCLCM Class of 2023

As I walked through the metal detector, what struck me first is the smell. Unpleasant, almost putrid, I hadn't encountered anything quite like it before. The smell of dilapidation. Of neglect. It was the end of my first week of "real" medical school. Earlier that same week, I was introduced to my longitudinal clinic on the main campus of the Cleveland Clinic. But this wasn't like that. This was a homeless shelter. Unlike where I had shadowed a few days ago and attended class earlier that day—buildings gleaming from glass and marble, the fruits of one of the wealthiest hospitals in the world—this place was run down, seemingly functioning on the dedication of its volunteers and staff alone. And here I was, a clueless first year medical student, volunteering to take vitals and counsel its residents. What had I gotten myself into?

As the patients started slowly streaming into the small room we had set up, I recognized this is what I had been working towards for the past five years. The long hours studying in college, studying for the MCAT, and doing research.... And now I was here, at last, seeing patients. But I never expected to feel this inadequate. I felt like I knew nothing. I did know nothing. At least nothing very useful. If these patients needed a detailed accounting of the anatomy of the heart chambers, I had them covered, but otherwise I was an imposter in my white coat.

I greeted my first patient. "What brings you in today?" I asked, hoping I didn't appear as awkward as I felt. He was a soft-spoken middle-aged gentleman who wanted a routine checkup. I escorted him to the blood pressure station, fumbled with the cuff, and managed to get, by some small miracle, an accurate reading (that was graciously checked by a second-year student). A wave of relief hit me, until I realized I needed to talk to this patient about what his result means. 145/100. It was simple in theory. Explain a healthy blood pressure range and how healthy diet and exercise can help him achieve it. So why did I feel so unprepared for this conversation?

It was because this patient—this person—had such a different life experience from me. Although I struggled to adapt to life with a visual impairment, I had never lacked for food, shelter, a loving home, and most importantly, opportunity. How do you advise someone to control their diet when their meals are predetermined by the shelter they live in? How do you persuade someone to develop an exercise routine when they don't have the luxury of meticulously planning their days in the face of poverty? This was completely out of my realm of experience. In that moment, perhaps more so than any other, I recognized the immense privilege I had benefitted from throughout my life. And now, despite that privilege, I needed to connect with this patient.

I briefly explained the basics of his results. But then I started asking questions. "What do you make of this result?" He acknowledged it was high and wanted to try to get it lower. "Tell me about your routine. Maybe we can find ways to incorporate some healthier habits." He confirmed that the pre-set meals of the shelter made it difficult to control what he ate. I tried making suggestions that were more practical, like eating more slowly and conscientiously, remembering having read that slower, more deliberate eating helps prevent overeating. He seemed receptive to this, which encouraged me to engage further. He shared that he loved sugary snacks. I chuckled with sympathy, telling him about my own sweet tooth, and suggested moderation rather than going cold turkey.

At the end of our conversation, before we walked over to the attending physician to wrap up his visit, he thanked me. And he didn't thank me with a platitude that we have become accustomed to in our day-to-day interactions. He thanked me with palpable, piercing sincerity. I returned the thank you, thinking to myself that he had done far more for me than I had done for him.

As we closed shop for the day and debriefed with the attending, I realized that it had all been worth

it. All the work I had put in to get to this point. As uncomfortable as I felt in my first real patient encounter, I had grown from it in ways I could not have anticipated. My patient's gratitude resonated with me at a deep level. And although even now I realize that not all patients will express gratitude or open up about their concerns, this experience taught me lessons that I hope to carry with me for the rest of my journey as a medical student and professional.

We won't always have the luxury of common ground to help us connect with our patients. And yet, we will be faced with the challenge of establishing trust and rapport regardless—the central premise of the patient-

doctor relationship. But this challenge provides an opportunity. An opportunity for genuine curiosity and engagement that is often lost in comfortable, familiar social interactions. Curiosity isn't merely a courtesy here, but a necessity. For it provides the conduit through which we can understand the context our patients inhabit and, using that, help us determine how to best care for them. And if we are so fortunate to discover that this context is completely outside of our realm of experience, we also discover an opportunity for growth and reflection. Reflection on the perspectives we have failed to consider either out of ignorance or apathy, and the advantages—big and small—we have all been blessed with in life.



Aiman Thinking

Anthony Onuzuruike | CCLCM Class of 2023

For many, he is just staring ahead. However, this digital sketch captures the essence of a medical student who is looking towards the future and yet contemplating the present. On one hand, he is learning about the different organ systems. On the other hand, he is imagining the implications of his knowledge for future patients and for the research needed to advance the field.

I wanted to tell you that I understand.

Not in the hollow, placating sense but in the I-have-truly-sat-where-you-sit-now sense. I can see it in your face; the forced bravery. You don't want to, can't possibly, admit that this is happening to you. You cling to statistics and epidemiology. How could you, a young, white woman from Michigan have Tuberculosis? Isn't that a disease from the 20s, the developing world, or anywhere else that isn't here, now, and you?

Did I say Michigan? You are from Ohio, I remember now.

Countertransference.

I remember the forced bravery on my face - clinging to the hope that this was a bad dream, a mistake. A false positive.

Until it wasn't.

You start to cry. I know what broke you, because it broke me too. The masks. "Just a precaution" they say with their words, but you hear it, and I heard it too.

"You are dirty".

Contaminated.

Contagious.

Countertransference.

You worry out loud, finally confessing your fears: will this affect your loved ones? Your children? My arm moves to take your hand, but I am too far away. I am trapped in my 18 year old body again. Isolated. Figuratively and literally.

I want to tell you. Hold your hand and promise that no matter what happens, I will not pull my hand away, reassure you that I am not afraid, because I know what you are going through. I tried to tell you with my eyes, could you see me? I screamed it from the inside of my head, could you hear me?

Maybe it is selfish of me to try and share this moment with you. I would have been comforted to have company all those years ago, but would you? Unsure of the answer, I say nothing. I leave. I turn back feeling bolder, but they have finally hung the contact precautions on the door. And I hesitate. Statistics say that the chance you are actually infected is miniscule, 1 in 100,000 is what they told me. Even less likely that you are infected and contagious.

But you could be. It didn't stop me the first time, but now there is a sign on the door. Protocol shouldn't keep me from comforting you. But is it really for you?

Countertransference.

I crouch in the dark,

lifeless,

waiting, for light that will not come.

I venture into the dark,

numb,

waiting to adjust.

Unmoved and unmovable,

withdrawn and abandoned to myself.

Unmovable, both he and I,

alone in the moment of discovery.

With only one way out,

the will to move escapes me,

and the thought to do so exhausts me.

I am paralyzed,

with his lifelessness at my feet and

vitality splattered on the walls.

The desire to be free ensnares me, draws me,

drags me toward peace.

Who did this to him eventually melts

into why did he do this to himself.

I wait no longer, nor dare wait longer,

so sorry, so shamed, to run from those who love me,

but I can not go on.

Why?

Why so desperate?

So lost?

Why did he not reach out?

Why did I not see it coming?

What could I have, should I have, done?

In dreaming how, I cower from the thought that

pain be married to my escape,

but the quickness and finality draws me,

rather than a slow descent into sleep.

So sorry for what I did not do,

guilt-ridden, I flee but there is nowhere to flee to,

like a macabre fugue, echoing in staccato, it follows me.

It is not that I do not want to live,

it is just that I do not want to live like this.

No farewell, no warning, no reason to grasp ...

Do not think, just pick it up and pull...

Only with forgiveness will come release.

Over 5 million people around the world each year lose a loved one to suicide.

Kindness matters, to each other and to ourselves. Hope matters.



I am one of the many doctors who relish the zen of flyfishing. Standing in a stream, reading the clues for what type of fly to cast and where to cast it, and focusing incessantly on a dry fly drifting lithely to entice a hungry trout, flyfishing invites self-reflection through the cadence of the flowing stream and the rhythm of the cast.

There may be several reasons that draw doctors to flyfishing. As in the practice of medicine, flyfishing combines cognitive and technical challenges and requires prowess in both to be successful. The seasoned angler is taking in and synthesizing environmental data in order to generate a hypothesis. Do I hear grasshoppers, such that a hopper pattern cast near shore is the plan? Do I see fish rising, such that a dry fly would be better? With a dichotomous outcome — the fish either takes the fly or does not — the hypothesis is that if I choose a particular fly, cast to a specific place with a precise presentation, then the fish will take the fly. If..., then..., just like practicing medicine. Even if my hypothesis is correct, whether I actually catch the fish, of course, depends on a delicate mixture of serendipity and skill, much like the patient's outcome in being cared for by a skilled clinician. In the parlance of flyfishing, the fish may take my fly if I

cast a parachute adams at the tailout of the riffle. Here is another commonality between flyfishing and medicine: both have jargon that is shared by colleagues, economizes communication among them, and may elicit quizzical reactions from others who may regard the language as quirky and strange. What is a parachute adams? What is the bronchus intermedius?

Like many specialties in clinical medicine, flyfishing also requires technical prowess. The act of casting is about understanding the physics of loading the rod in order to store and then release kinetic energy, which propels the fly line forward even though the fly itself is virtually weightless. As another dimension of fly angling, tying flies is an exacting craft — assembling tiny amounts of material on the shank of a hook to simulate the appearance of a bug or baitfish. Building fly rods is yet another art form. So too is the practice of medicine.

Flyfishing is similar to the process of scientific inquiry. Indeed, the act of casting to a fish can be likened to a clinical trial; the results of clinical trials are the bedrock of evidence-based clinical practice and the cast is the central element of flyfishing. The clinical trial, like the approach to

the fish, starts with a hypothesis — which fly, cast where, and how? Successfully conducting a clinical trial requires precise administration of the study intervention — the medication must be administered in the correct dose; the surgery must be carefully performed; or the device must be skillfully placed. The cast must also effectively present the fly in the right way, place, and moment in order to produce the desired outcome. Furthermore, as with clinical trials, the outcomes in flyfishing are clear and dichotomous. The fish is caught or not. Except for the occasional confabulatory fish tale that is told among denizens of fishing lodges, whether the fish was caught or not is generally not subject to debate. Quantitative metrics apply. How many fish were caught and how big was the largest? Other than the hyperbolic proclivities of some anglers (and, I suppose, some doctors who regrettably commit scientific misconduct), size and number are objective truths.

Still, in discussing the outcomes of flyfishing, most seasoned anglers would quibble with the idea that the outcome is dichotomous, and is merely about whether the fish was caught or not. The real point, they would say (and I would heartily agree), is being there. Flyfishing is a surrogate endpoint, an excuse to be in a beautiful place, highly mindful of one's surroundings, and focused on a tiny fly in pursuit of a fish, the whole activity making the issues of the world — and one's own — melt away. The goals of medicine are also not summed up solely by dichotomous outcomes or quantitative metrics. The real point of being a great doctor is being fully present for the patient.

An executive coach once pointed out to me that doctors seek two things as drivers of their careers: mastery and impact. We want to be really good at what we do and we want that mastery to benefit people's lives. So too with flyfishing. It takes many years of study and deliberate practice to become a really good doctor; and it takes lots of time on the water to become a great fly angler. One could say that mastery in both is actually elusive — we never fully achieve it, but we continuously and incessantly seek it.

It would seem that the popularity of flyfishing among doctors is not at all coincidental. It is the predictable consequence of a deep commonality that both medicine and flyfishing share — a passion for challenge, the quest for clear success in our efforts, an appetite to continuously get better at a challenging undertaking through deliberate practice, and the hope to make a difference through excellence.

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You see a small spark in the distance
The light subtle yet forceful, hostile yet gentle
It draws you in with an alluring glow
Inviting you to come closer
For just one touch

You approach the flame, glowing softly
Tempting you with warmth and just a hint of danger
Heat penetrates your skin, into your core
Melting fears and inhibitions
Leaving one desire

You lean in close as the fire glows
Not just in front of you but now burning inside
It becomes your passion, your only goal
No, you cannot live without it
Not for one second

You hardly notice the blaze consume
Your heart and soul, your hopes and dreams, even your life
Once thriving, now reduced to ash and dust
You fall down to your knees and beg
For one more chance

You are engulfed in the inferno
Gasping for a single breath of air in your lungs
You cough, choke, and suffocate in silence
But too ashamed to call for help
So... no one comes

This is a poem I wrote when I developed an eating disorder (bulimia). I felt so alone. I chose to share this to show you that you're not the only one struggling with something, whether it's an eating disorder, an addiction, or something else entirely. The best thing you can do is reach out to someone and ask for help. I'm glad I did.

Knock, knock, knock “Good morning! The whole pediatrics team is here to check on you.” As we crowd into the small room, I glance at the nanny sitting just adjacent to the head of the bed, where the 3-year old patient rests quietly. I watch as the resident relays the care plan, knowing full well that the eyes and ears of the attending are locked into every word. The walls are white, but becoming more and more covered by the scribbles of the 3rd year medical student writing down the resident’s instructions. It seems that everyone in the room is playing an important role in the care of this young child, while as a 1st year medical student it feels as if I am just a fly on the wall. In fact, I feel my role is more in line with that which was being encompassed by this young patient lying in the bed. Motionless but present...conscious but quiet... unengaged but deeply aware. Sure, my role is to shadow, but can I really consider myself a part of the team? What am I contributing?

After the resident finishes presenting the care plan, the attending performs a quick physical exam on the patient. “Your turn, go and exam him.” Neither the resident nor the third year medical student responds. Who is she talking to? It can’t be me, I can barely perform a heart and lung exam on an adult, let alone a toddler. My gaze is focused on the patient, but when I look up to the attending, her eyes are locked on me. My heart begins to race; a product of some strange mixture of excitement and nervousness.

I was being given the opportunity to contribute to the care of this child.

This is the reason I came to medical school, to play an active role in improving the health and well-being of children, but the question quickly dawned, what can I truly contribute? Sure, I can walk over to this patient, listen to his heart and lungs, and give him a smile, but is the net gain for me or him? I struggle with the realization that examining the child is beneficial to my education, but likely not to his care. Just two months into my medical education, every patient I examine provides me a wealth of new knowledge and experience, while they receive little in response due to the still lacking pool of this experience and knowledge.

With each patient, my knowledge increases and my ability to contribute something significant to a patient’s care increases. At some point, I know that the scale will tip, and the patient will be the recipient of the net benefit of each interaction. It is an uncomfortable feeling, though, to know that each interaction at this phase consists of my gaining more from my patient than I can reciprocate in the care I provide.

As I walk over to the patient, I put my stethoscope to my ears, making sure not to embarrass myself by putting it on backwards. Remembering the feeling of a cold stethoscope when my own pediatrician listened to my heart, I slide my hand across the

diaphragm a few times to warm it up. When I arrive at his bedside, I give him a smile and show the stethoscope to signal the upcoming exam. My gesture toward him is met with an expressionless gaze. As I position the stethoscope over his heart, he remains solemnly still without even a flinch. I listen carefully for his heart beat, meanwhile he continues to stare up at me. His heart rate is just as fast as mine, but while his heart rate is due to the naturally rapid heartbeat of toddler, mine is a product of my nervousness and uncertainty.

Without a change in expression, he slowly reaches up his left arm and places his hand over mine on the stethoscope, continuing to stare up at me. Maybe the stethoscope is cold (despite my efforts), and he is weakly trying to move it away. Perhaps he thinks I am a “doctor” who can care for him, and he is reaching up in a state of trust. Or, could he see right through my act and be lending a hand of comfort to the one examining him.

In any case, his subtle gesture is a beautiful representation of the figurative “helping hand” inadvertently offered by every patient I interact with at this stage. Every heartbeat and breath sound is another pebble in the scale. Eventually the scale will tip and every nugget of knowledge provided by a patient will be wholly for their benefit. Until then, I will continue to be grateful for the knowledge imparted to me by every patient with whom I interact.



Perceiving the Other

Alice Tzeng | CCLCM Class of 2021

The Extra Mile?

Lestella Bell | CCLCM Class of 2020

Can you go the extra mile?
My road to here was long
My mother, she is tired
My father, he is sick
My sister, she is scared

Can I go the extra mile?
My shift has been so long
My mind, it is so worn
My heart, it feels so numbed
My time, it goes so fast

But I haven't yet forgotten
How it felt to ask
Can you go the extra mile?

Down the Wormhole

Seysha Mehta

It was a beautiful sunny day in Cleveland as I drove to the summer camp for inner-city Hispanic middle-schoolers. I had just started serving there as a counselor for a high school service-learning project. I was very excited and also a tad nervous as my mind dwelled on the opportunity to practice my Spanish, the chance to influence minds just a few years younger than mine, and make new connections. I quelled my anxiety. After all, how difficult could this be? These were school kids, just like all the friends I had made over the last few years. This couldn't be too challenging, could it? I went to one of the best private schools in the area - there was so much I could teach them.

One of the girls (let's call her Sonja), a 13-year-old whose parents had immigrated from El Salvador, had already adopted me as her big sister. I had missed her yesterday as she was absent without notice the day before. I wondered if she was unwell, a part of me criticizing her parents for not calling in to let us know.

As I parked and walked into the building, I was reassured to see Sonja smiling, looking well and waving at me. She ran to me and smothered me in a huge hug. There was a mischievous spark in her eyes as she dragged me to a quiet corner. "I want to tell you something," she said with a hint of pride.

"Sure, let's go outside. It's beautiful in the sun," I said, wondering what this was all about.

She could barely contain her

excitement. "Guess what I did yesterday?"

"Rode the Millennium Force at Cedar Point?" I ventured, recalling my own first visit to the amusement park, not sure what else could generate so much excitement in a young teen.

"No, silly. I spent the day in the woods with my boyfriend! I finally did it!" she gushed, searching my face for a response, a sign of approval, maybe a congratulatory nod.

I sensed my jaw dropping and my eyes staring at her with disbelief as I involuntarily leaned back from her in shock. I heard my first words stumble out, "Did you use protection?"

Puzzlement, disappointment, irritation - many emotions chased themselves on her face. Clearly, she sought approval from me for her reaching this milestone, something that her peers seemed to have achieved a while back. She was confused as she could not see where I was coming from, disappointed to not get that high-five, and irritated at my lack of understanding.

I scrambled to quickly recall my biology lessons at school, the birds and bees conversations I had with my physician parents, and the advice from my pediatrician. "When was your last period? Did you get your HPV vaccinations? Does or did your boyfriend have other partners that you know of? What did your parents say?"

At the last question, her emotions

changed to fear. "Don't ever mention this to my mom, OK? She will say it is sinful and ground me for the summer. Swear you will never tell her!"

"How about your pediatrician?" I queried hopefully. She went to a clinic at the county hospital where she saw a different provider, often a resident-in-training, each time. I was in a quandary - I really knew nothing of resources available to an inner-city teen. Her school nurse was unavailable during the summer break. She clearly needed to connect with someone whom she could trust, whom could advise, guide, and take care of her. While I helped her the best I could, I felt inadequate and helpless.

Nothing in my life had prepared me for this situation or realization. I never had to worry about finding someone to trust, and I always had so many people to answer my questions. It really hit me - basic health literacy was not as universal as I had been made to believe. Knowing what resources are available is not common knowledge. Having someone who always watches out for you is not a reality for everyone.

In my "The Truman Show" moment, I saw the cocoon of privilege that had shielded me from Sonja's parallel universe that existed right here, a few miles from where I lived. The curtains had been peeled back. A portal had opened up, and I had taken the first steps down the wormhole. My worldview would never be the same.



Incheon

Wenda Ye | CCLCM Class of 2020

Fading

Alice Tzeng | CCLCM Class of 2021

The sweet memories of you are fresh roses,
Vibrant, heady, and alive,
Playing infinitely across my psyche,
A priceless recording cycling,
Reliving over and over precious moments,
I hoard those times like pearls,
From them my cherished fortune's been made,
Thinking, longing, begging for you,
To treasure the memories as much as I,
So listless I travel home ever-thinking,
Lost in those happy recollections,
Until the roses fade, the recording breaks,
A betrayal by my fallible mind,
I sob; I can't bear to let go of you,
But reality harshly jolts me back,
The memories of you fading, fleeting...
And I must face the emptiness of life, alone.

Everyone was awaiting her arrival in one of the corners of the hospital floors where chairs had been placed but no one really ever sat. The seats were rearranged into an awkward circle of sorts, and members of the various medical teams were positioned so that only one seat remained open for her. They were strangers to her, and they were strangers to each other. They had decided it would be best for the primary team to deliver the news.

Her wedge sandals clacked as she rounded the corner. She was a short woman, brown curls bouncing with the pep in her step. Members of the team motioned for her to sit, and she obliged, pulling out her notebook filled with scribbles of dates and words to look up later. Her pen hovered above the page, eagerly awaiting the oncologist's words, like an obedient student on the first day of school. Words started coming out of his mouth, and she would repeat them after him while she furiously wrote everything down, hanging on to his every word like her father's life depended on it.

"Clinical trials? What kinds of clinical trials? You mean that these drugs would be experimental?"

One by one, frowns began furrowing the brows of each member of the other medical team at this meeting. Clearly, the two teams had different priorities. They had spoken to each other prior to the meeting, of course. The neurologist and her team had arrived on the floor and relayed the events to the oncologist, and he had nodded in acknowledgement, hearing but not listening. To the neurologist, the imminent matter at hand was the 3 centimeter by 4 centimeter hyperdensity on the CT scan that even a second year medical student knew the meaning of. Surely, he knew that this was the wrong time to be explaining the mechanism of action of the clinical trial experimental drug he was discussing with the daughter. Surely, he knew that it would all be for naught.

By this time the neurologist had already exchanged a number of befuddled looks with her resident. She interrupted, which was clearly out of character for her gentle and unobtrusive demeanor.

"I'm really sorry to interrupt, but there has been a new development with your father's condition. He has had a significant brain bleed, and it may be serious enough that he won't be able to recover from it."

The daughter's hand flew to her mouth. Then, things began moving in rapid succession. Her father had already been transferred to the NICU, she was informed. Soon, she was being ushered towards a different floor, all the while the medical student at her elbow was doing her best to comfort the inconsolable woman who, to eyes of the other medical staff and patient families roaming the halls, looked to be out of her mind. Distraught was an understatement. She had pulled out her phone and was showing anyone who made eye contact, her hair flying as her head swiveled, looking around in desperation, her voice reaching an unbearable volume.

"Look! Here he is! He's dancing! Just a week ago he was dancing with the nurses, and they were telling him how well he looked!"

The video showed an elderly gentleman, dancing and spinning his partner. He looked vibrant. He looked happy.

This charade went on because they could not find a room for the daughter and her companion, a friend of her father, where they could discuss next steps. They flitted from floor to floor, looking for an appropriate place that provided privacy.

Finally, they were able to find someone to unlock a room where they could sit and talk. The daughter eventually calmed, and the NICU doctor explained what would happen next, providing cautious estimates of chances.

After that discussion, the neurology team moved on. They had other patients and stroke calls to address. Sometime later the neurologist and the medical student returned to the NICU to visit the daughter. She seemed to be more at peace with what had happened. In the middle of their discussion, the medical student peeked around the daughter, past the curtain that partially obscured the patient room, to look at the father's face, wondering and hoping.

Her father passed later that day.



Metamorphosis Chan-Mi Lee | CCLCM Class of 2021

This is a drawing from when I was entering womanhood, soon after I turned 17. I was nearing the end of my undergraduate studies, preparing to leave New Zealand, full of hopes and fears, and riding through the rough waters of reality when I drew this. It was my way of escaping from the noise outside, and my way of dealing with the secret pain that I couldn't be closer to someone I liked (you know, girlfriend-boyfriend type of thing), because I was moving to Canada.

I have given away several of my best drawings to people I loved (in fact, almost all of them). It was a way to give them a piece of myself, because I often put a part of my soul into drawing them. I didn't have a cell phone back then, so I don't have pictures of them either.

But this is one piece that I did not give away. It reminds me of my struggles at the time, but also of the peace and joy I felt when the butterfly revealed itself on the paper. Instead of focusing on the suffocating cocoon of reality, I dreamed of a better future to come. The drawing never had a name, but looking back 10 years later, I think it was a moment of metamorphosis for me too. So here it is – a piece from the past, to encourage you and me that there is beauty awaiting.

The Dance

Richard Prayson, MD

Tis wondrous solace found when hand meets hand,
to lift ourselves and carry kindred souls
toward the momentary center of our worlds.
Poised, anticipating the start of dulcet chords and notes
that will gently move ourselves to glide across the open floors
in deliberate concert.
Feeling storied measures guide our steps and turns,
right, then left, and back to right,
as if to float upon the air beneath.
Unbroken, rolling seamlessly from harmonious concord,
mirroring the vicissitudes of our together,
the syncopated rhythm of our journeyed lives danced as one.
The mere intrusion of a forgotten step causes but momentary pause,
as strains continue and the tide resumes,
tandem, together, tethered by one seamless burning light.
The world around forgotten in the moment,
but remembered,
as we surrender our ourselves cloaked in raptured bliss.
And as the surreptitiously approaching cadence of the music finds us,
poised, the silence wraps its arms around us,
twas heaven, the dance.

Of the Universe

Alice Tzeng | CCLCM Class of 2021

A cold night, a clear night
beyond multifarious silhouettes
above dim firefly streetlights
the heavens shimmer.

Starkly luminous
Orion stands vigil over the earth
his familiar, auspicious celestial belt
merging fuzzy nebulae with lustrous stars.

To the left
Sirius gleams
faithful hound
a pinpoint of bluish radiance infinitely far away

Glancing into the boundless void
all the space between stars
the overwhelming weight of the ages
the image of all that was hanging suspended
an eternal, intricate pattern
the greatest of creations.



Autumn Amber Daniel Moussa | CCLCM Class of 2021

I found Chicken of the Woods, the fungi pictured on the trunk of the tree, while walking through mud-caked leaves one crisp November morning. As I gazed upward, the sulphur shelves spiraled up and into the golden canopy.

Location: Near Ambler Park.

Mindfulness, Empathy, and Relationship-Centered Care

Leonard Calabrese, DO

We all have patients whose names, when we see them on our schedules, conjure up sensations of anxiety, frustration, dread, or even fear. The basis of these feelings generally comes from our past experiences with them, which we mentally label as “difficult patient encounters”. Unfortunately, these interactions are not uncommon. I think most of recognize this is not the patients’ fault but rather a situational problem, one more aptly viewed as a problem in which the difficulty lies in the relationship. In recent years, many suggestions have been put forth to reduce the frequency and impact of these types of encounters, including improving provider self-awareness, reducing factors contributing to burnout, and enhancing communication skills and empathy. I believe that one remedy to lessen the impact of the difficult encounter is the use of mindfulness techniques such as meditation.

Mindfulness, which refers to a process of bringing one’s nonjudgmental attention to experiences in the present moment, can be developed through a variety of techniques including meditation. Meditation is both popular and controversial, and much has been written in the past few years about the use of mindfulness/meditation for both the general public and health care in general. The hyperbole of the discourse that often surrounds mindfulness/meditation should make us rightly cautious over accepting claims, which have ranged from mindfulness as a cure for everything including all our stress, a way to enhance our memory and concentration, and a general balm for enhancing wellbeing. As in our school, some formal exposure to mindfulness is now being offered at the majority of medical schools, so perhaps it is worthwhile to consider how such training may enhance our wellbeing and our care. I personally have long been interested in meditation, but was a failure in developing a practice.

Before the internet age, learning mediation meant finding a teacher or a retreat or reading a book, all resources that were either beyond my grasp or failed attempts. Fortunately, after many years of failure, I finally was successful through use of one of the many online programs now available. Such relatively brief techniques now are readily available, and evidence suggests they may be effective adjuncts to enhance our personal care and wellbeing in healthcare.

The patient over whom this all came together is a man named David, whom I have cared for over the time spanning my pre- and post- mindfulness periods. He had come to see us after having been discharged from several of the other large medical centers in our area and was labeled as a disruptive patient. The first time I saw him, he was combative, and I was fearful of even being in the room. He indeed was a textbook case of the characteristics that we have traditionally viewed as emblematic of patients seen in difficult encounters with chronic pain, poorly managed mental illness, and numerous social challenges. In the early stages of our encounters, I would be anxious, angry, and fearful to the point that my advanced practitioner and I would strategize about approaches and exit strategies when he appeared on our schedule. Each visit was largely the same, and security would be poised to come if needed.

Some time after we began our relationship, I began to meditate and made some progress. I was never sure what I was getting out of it, but it felt good and that was enough for me. My first insight into the power of the practice came during a particularly stressful visit with David. He hurled invectives and screamed, and the team, as always, was ready to call security as they had done in the past. This time, however, I was able to apply my newfound skill to recognize and virtually see my feelings of agitation and anger.

I was an observer to my thoughts and not actually the embodiment of my thoughts for the first time. We had a relatively quiet end of the visit, and I reflected. From then on, I began to consciously practice my newfound skill from the onset of each encounter with David. In reality, I was largely keeping quiet, extending to him thoughts of compassion and being still. Over time, each visit became calmer and calmer. In fact, now we sit together, and it generally results in him expressing tears of joy because he says that I hear him.

So what has happened? Nothing has changed in terms of my patient’s poorly controlled mental illness nor life situation, but rather I have changed, seemingly buffered by my simple practice. Scientifically, there are data supporting the capacity for mindfulness to enhance empathy and compassion, and I believe that our shared silence was emblematic of this. Empathy is a powerful force in the patient encounter, and our understanding of it is still nascent. Helen Riess, author of the *Empathy Effect*, describes empathy as a capacity that has both afferent and efferent components, and it is the efferent component that patients feel. Some might say that I was merely applying advanced communication skills with structured silence, which indeed is powerful, but I believe there was more.

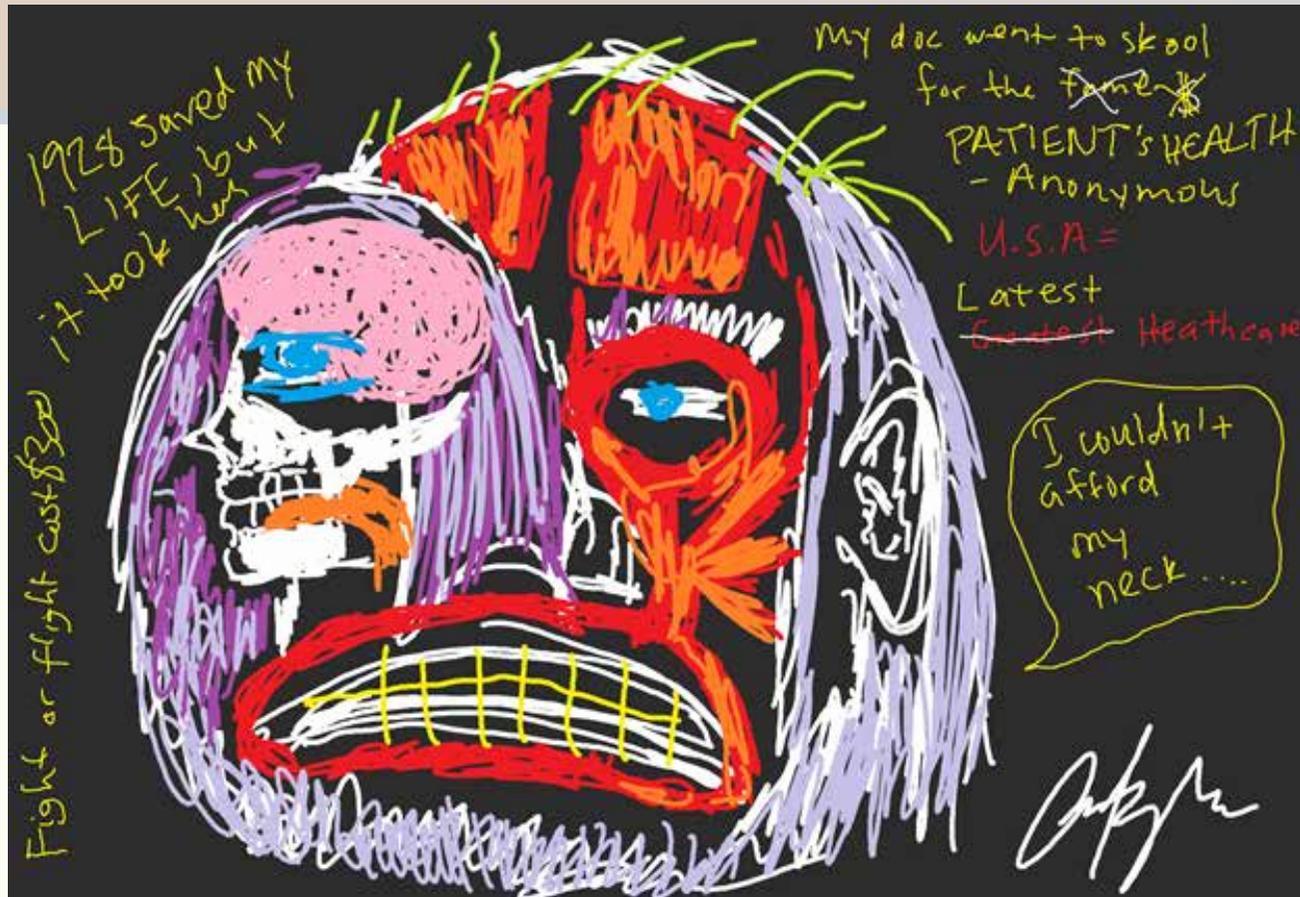
Samuel Shem (a.k.a. Stephen Bergman, MD), author of *House of God*, describes something he calls mutual empathy, a moment in a caring relationship in which not only do we see the patient clearly, but they see us clearly as well, and each of us senses the other feeling seen. Such moments can indeed power us individually, but moreover power the relationship between us even more.

We clearly need more work on how to buffer and build empathy in healthcare and perhaps mindfulness and

mediation is only one promising technique. What type, what dose and frequency of mindfulness remains to be elucidated. For now, I think there are sufficient data for healthcare workers and institutions to support bringing such resources to our workforce. The journalist and mindfulness mediation advocate Dan Harris reminds us that a few generations ago, if you were seen out running, people would ask you what was the matter with you. Today we all jog, or want to, because the science supports its health advantages and society embraces it. Maybe mindfulness and mediation will be the next big thing, but for now it holds enough promise that we should consider giving it a try. It just might work.

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Intertwine of Human Experiences Anthony Onuzuruike | CCLCM Class of 2023

In this digital sketch, a young woman's face is overlapping with an older man's face, which seeks to represent the similarities and differences people have with each other. This can also be seen with muscular and skeletal anatomical features on the man and woman. They share one eye, illustrating their similarities, but have different faces, highlighting the differences in their experiences. In this instance, the man and woman are father and daughter.

Etched in the background are various statements. One reports the discovery of penicillin in 1928: a major breakthrough of modern medicine as certain infections could now be vigorously treated. Unfortunately, the woman in the painting passed away due to an allergic reaction to penicillin, emphasizing the "it took her [life]" statement. Furthermore, her death is represented

by the skin and bone features. Her face is over her father's face as he often thinks about the opportunities she would have had if she were still alive.

Other phrases hint at the state of healthcare in the United States. "Fight or flight cost \$300" is a reference to when the EpiPen price hiked to \$300 a pen, leaving those who couldn't afford it and needed it subject to anxiety. Others hint at the idea of whether or not we should treat health care like a commodity. The bubble quote stating "I couldn't afford my neck" pokes fun at the digital sketch itself and is supposed to further represent the state of our healthcare system. Based on how our healthcare system is set up, deciding on when to go to the doctor is often a medical and financial conundrum.



We are the World Anthony Onuzuruike | CCLCM Class of 2023

This piece attempts to tackle the question of what the world would look like if everyone had the same chance to be healthy, safe, and happy. This prompt, along with the song "We are the World", co-written by Michael Jackson, gave inspiration for this work and its title. It depicts men, women, and children holding hands in rows. It is also colored in an array of hues and patterns. Individuals in the picture have a single description of what many would label them. However, they are multicolored to represent the diverse experiences they have all gone through and illustrate that people are more than just the labels they are given. Unfortunately, this is a challenge that all have experienced as we fight to be seen as more than a single label. In addition to the multicolored

individuals, the scattered background represents the situations people will go through that will shape them later on. Nevertheless, despite the labels that tend to separate us, we are all connected. This connection is represented by the holding of hands. Ultimately it is represented by sharing the same page, as the CEO, the homeless, the religious, the college grad, the survivors of abuse, the orphan, those who we have lost, and those who will come are seen together as equals. We all share the world. When we see each other as such, there is room for empathy, care, and love for one another. We all bear a unifying image. That, in a nutshell, is the hope of the world.

"If students reduce time and effort devoted to preparing for Step 1, they may indeed devote attention to other activities that will prepare them to be good physicians. This would arguably be an ideal outcome of such a change. However, it is possible that if students were to devote more time to activities that make them less prepared to provide quality care, such as binge-watching the most recent Netflix series or compulsively updating their Instagram account, this could negatively impact residency performance and ultimately patient safety. We know that assessment drives learning, so another concern resulting from a shift to pass/fail scoring may be a less knowledgeable physician population."

- Peter J. Katsuftrakis, MD, MBA and Humayun J. Chaudhry, DO, MS (CEOs of the NBME and FSMB) in response to an article written by medical students published in the same journal, later edited to exclude the portion highlighted in bold.

Dear Mr. Katsuftrakis and Chaudhry,

I recently read your response to a rather civil and reasonable opinion piece written by my colleagues, and it seems to me that you made quite a number of assumptions, which I address in the following.

First, what we medical students do in our increasingly limited spare time is actually, believe it or not, none of your business. Last I checked, NBME and FSMB stand for National Board of Medical Examiners and Federation of State Medical Boards, which are regulatory bodies for governing examinations and licensing for medical students and physicians, not for governing the "activities" in which we choose to engage.

Second, I would like to address your assumptions about our generation. We understand what you are insinuating with your comments. That we "binge" watch and "compulsively" update Instagram because we do not have self-control and because this generation is somehow of weaker moral fiber for using technology that makes our lives more convenient and fun. This is actually not the first time we've

been shamed for using technology too much, so congratulations on a completely unoriginal insult. It is ironic to me that by making known your belief about our generation, you confirm the very point that the medical students were trying to make in the original article, that "students push themselves to their physical, psychological, and interpersonal limits to succeed in this environment." Did you even bother reading the article before writing a response?

What if Netflix is how we connect with long-distance partners or spend quality time laughing with friends? What if Instagram is how we show friends that we never get to see what we've been up to, what excites us, moves us, or makes us laugh? What if engaging in technology is how we learn more about our world, exchange information and viewpoints, and explore the creative forces that humanity has to offer? Or maybe we just use those things to escape reality and seek the validation that we don't receive from the medical system.

Oh, and by the way, we saw your "Mea culpa" tweet, and our generation calls that, "Sorry, not sorry."

And last, I would like to address your assumption that studying for a test leads to better patient care. I don't think anyone is arguing that medical knowledge is important. You assume that more time and effort studying leads to better Step scores and hence better patient care, as if we are robots that only read and study and have no need for enjoyment or pleasure. But don't get me wrong, I do enjoy a good study from time to time. Here are some for your reading pleasure:

Here is a study showing that time spent studying did not correlate with scores¹.

"USMLE Step 1 and 2 scores are not correlated with reliable measures of medical students', residents', and fellows' clinical skill acquisition"².

When looking at surgical residency success "their positive predictive value was only 50% for higher faculty evaluations and a high overall board pass rate can be achieved regardless of USMLE scores"³.

Actually, maybe you said it better: "Does Step 1 performance predict residency success? To our knowledge, no study has been done to answer this question."

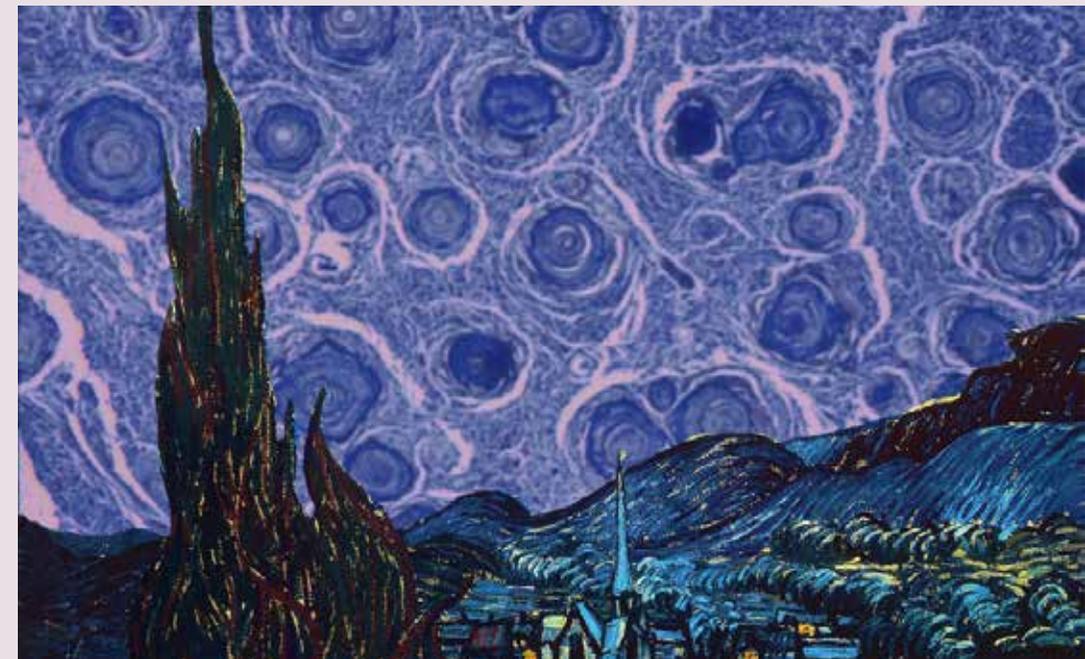
Do you want to really know what negatively impacts patient safety? Lack of sleep, which leads to mistakes and poor judgment. Lack of emotional and psychological safety that leads to not speaking up when an error is being made. Let's not forget that we are just as human as the patients we care for and that caring for ourselves is caring for our patients.

I understand – you did not become CEOs of your respective organizations by rejecting the status quo, but medical students should be able to make their opinion heard in a respectful, well-written manner to the Journal of the AAMC without being denigrated and insulted. But I suppose that is why we are training a generation of potential new CEOs.

Sincerely,
Angry Medical Student (written in between perusing Instagram and watching Netflix)

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Replacing the background in Van Gogh's notable work *The Starry Night* is a psammomatous meningioma (color altered), resembling the cosmic swirls found in the original piece.

A Starry Psammomatous Night *Datta Sudarshana* | CCLCM Class of 2019

There are no beds or monitors or other such things to identify this place as a hospital, but

I see you.

I see you

Silently walking hand in hand, caressing each other's fingers. Do you always hold hands? Or, are you providing strength to each other, as you face the unknown.

I see you

Staring at the welcome sign written in more than 20 languages. Are you appreciating it as a work of art? Or, are you finding some level of comfort seeing the script, welcome, in your native language.

I see you

Your unkept self and identification sticker placed squarely over your left breast. Your child is here. I hear you. "He's been awake all night. His sippy cup is broken and he won't drink from anything else. I'm going to Walmart."

I see you

Your abandoned jigsaw puzzle. 1000 pieces are two thirds connected. Solid green; the outline of a butterfly. Your handwritten note reads, "Went to dinner. Be back soon. Feel free to complete, if you can. Please, don't remove."

I see you

In Starbucks, draped in nothing but a hospital gown. IV pump running. Heparin 1400 units. Are you thirsty or just looking for a sense of normalcy in your current world that is consumed with sickness, pain, and suffering?

I see you

You and your tear stained face running into the bathroom. I hear you in the stall next to mine, uncontrollably sobbing, choosing not to be seen.

I see you

Standing in a corner, your futile efforts to hold back your tears. I hear you. "He was able to hold him one last time. He got to say goodbye."

I put away my coat and turn on my computer. The phone rings. Good morning. This is Mary Jo. I'm a registered nurse. How can I help you?

Fellow students, CCLCM staff and faculty, family and friends:

It's an honor to be here with you today, celebrating the students who are graduating from our medical school. I'd like to share some thoughts about the then and now of this class.

A few years ago, all of the graduating students arrived here, no one knowing each other. Since then, much has happened. Every one of the graduating students has worked hard. Every student has traveled an enormous distance in terms of material learned. Every student has had important accomplishments.

But let's take a step back and evaluate some of what's been achieved, some of what is yet to come, and some hopes and dreams that might materialize.

When you, the students of the graduating class, arrived here, all of you had been successful in school. All of you had high grades in college, high test scores, and more. Each of you had been a "winner" in an ultra-competitive, highly individualistic educational system. All of you had hopes of becoming some sort of physician.

And then you came here.

You knew before coming here that educational practice in this school did not include grades, tests, or class rankings. And then, from the first week of matriculation, you began to experience, some of you with clumsiness or frank difficulty, an important mantra of our school: We are here to be colleagues in the fullest sense of that word, to work together, to teach each other, and to learn from each other. The staff of the school set out to do this, all the while encouraging each person's individual interests and dreams. We tried to achieve these goals in various ways: through small group problem-based learning sessions, interactive seminars, research projects, and through the creation of numerous evaluation portfolios that required critical self-assessment and honest reflection.

And here we are.

It's now several years since your matriculation here. You were chosen to be part of our program because of your earlier achievements and our perception of your potential. That included our hopes that you would have a collegial sensibility, be an avid lifelong learner and a kind and effective caregiver.

Some of our goals have already been attained. On the first day of attendance at my fine medical school, an esteemed faculty member said: "Look to the person on your left, then look to the person on your right. Only one of those two persons will graduate with you." While that statement was clearly intended as a joke, it helped set forth the culture of learning that we became part of that included, besides academic excellence, extreme competition and a very limited sense of collegiality and community. In contrast, as you now look at the person on your left and the person on your right, you see persons with whom you collaborated and shared important learning experiences. For now and forever, you have each other. This is a great success that you've been part of and an everlasting gift both for your professional career and your personal life.

You were also chosen to be part of our program because of our belief in you as a change maker. You, members of this graduating class, will soon be traveling in many different directions, building on what has been learned here and entering a new phase of your lives. No one has a crystal ball that can predict our trajectories, our personal and professional outcomes. But this much is certain: it's more than knowledge that you gained since being here and, as the saying goes, "To know is not enough". You leave here, not only with a superb foundation in the science of medicine, but also with a well cultivated sense of respect for one another, the collegial practice of medicine, and the importance of each patient and family. Each of you, in your own distinctive ways, will be of help to others and make inroads in repairing the world. The world will be a better place because of you and what you'll provide.

CCLCM Commencement 2019: Then and Now *cont.*

Marvin Natowicz, MD, PhD

One more thing. Your achievements, earned through your years of hard work, have taken place in a particular context. I've already mentioned the CCLCM faculty and staff who have been your partners and who, in the most romantic sense of being a teacher, have worked to raise you up so that you will be able to see things that we can't see and achieve things beyond that which we have done.

But there is another part of the context that needs recognition. All the wonderful things that you see and do are, in considerable part, a function of the loving

support that you've received from your mothers and fathers, brothers and sisters, spouses, partners, and dear friends. So, while we celebrate you today, we also should celebrate all those who've stood by you and assisted you in your journeys.

You, students—our hopes for the future—have already achieved much and are poised to do much more. As Neil Young has said: "Long may you run."



Plant Wenda Ye | CCLCM Class of 2020

To a New Wave of Pioneers

Kathleen Franco, MD

It is amazing that we have gone nationally from no women in medical school in 1845 to more women than men in 2018. It has taken over a century and we owe a lot to the original pioneers who persevered and jumped many hurdles. Even only one generation ago there was often only 5% to 10% of women in each medical school class. We were told by those women ahead of us: "You have to work harder than the men; stay longer; and don't get sick. Remember if you are successful, those following you will have an even better chance." In the early 70's, we still thought of ourselves as pioneers. Pioneers sacrificed and made painful decisions about going in to work even when they were sick because it demonstrated fortitude.

My oncology professor told me she and her husband decided to never have children. It would have been too much of a sacrifice. She told me that she was relieved that women students of my age would be able to change that. We did, although there was much more to do to truly bring work-life balance. What is yet to be done is to give credit for that: rewarding physicians for doing something that promotes healthy decisions and not just RVUs. How we model ourselves for others who observe us, like our colleagues and students, should also matter.

When I was a student, physicians and patients smoked in the outpatient clinic. Can you imagine trying to talk to a patient about smoking cessation and how that could benefit them? Then there was the issue of weight and couch potato exhaustion. Convincing patients to make lifestyle changes that doctors had not successfully accomplished was a definitive hurdle. It was not that unusual for patients to directly ask the doctor why they hadn't changed. Now it is more typical that physicians want to have a healthy diet and exercise. It is still an uphill climb.

One category of the old annual performance review system was collegiality. Yes, we take care of the patient "like a member of our family," but we must also care for our colleagues and team members in the same manner. The most important milestone in adult development is generativity. That is the goal.

Thank you for watching out for each other. You are the next wave of pioneers for healthier physicians and role models.





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