

PCM VOICES

Reflections by PCM Scholars Volume 3



PATIENT-CENTERED MEDICINE (PCM)
SCHOLARS PROGRAM
2012-2017

*This issue of PCM Voices is dedicated to all
Program Faculty, Staff and Community
Partners who have given their time, energy
and wisdom to helping our learners grow and
blossom into compassionate, caring and
competent health professionals.*



Please Note: *Names have been changed to protect
privacy*

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Foreword

As health and health care and the related evidence base continue to evolve, the value of building humanistic, compassionate and collaborative patient-clinician relationships remains pivotal. At this time of development of transformative models of health care practice and delivery, there is increasing recognition of the role of health care professionals in not only providing value-based care to patients but also serving as leaders and advocates in addressing social determinants of health.

The “Patient-centered Medicine (PCM) Scholars Program” at the University of Illinois at Chicago College of Medicine spans undergraduate medical training. The primary purpose of the overall curriculum is to equip physician trainees with attitudes and competencies likely to ensure that they can and will practice patient-centered medicine for all patients, including those who are vulnerable and undeserved. Drawing upon the wisdom of great educators and philosophers, including John Dewey, Earnest Boyer, and David Kolb, learning experiences are grounded in an “Education in Action” philosophy. Active-experiential learning, reflection, application and integration are vital pillars of the curriculum.

The curriculum includes a Service Learning Program that involves students in the direct care of undeserved vulnerable patients in selected concentration areas: Geriatrics, HIV/AIDS, Homelessness, Immigrant & Refugee Health, and Intimate Partner Violence. A central thread of the curriculum is students’ ongoing involvement with selected patients, including undeserved patients, over the course of their training. Given the importance of inter-professional education and collaborative practice for understanding and addressing key health issues of our patients and communities, we have added a new course “Inter-professional Approaches to health Disparities (IAHD)” to the program. The IAHD course includes students from different professions working in inter-professional teams to develop and carry out community-based participatory research (CBPR) projects aimed at addressing the health needs of marginalized populations. Addition of this inter-professional element has immensely enriched our collective learning.

The PCM Scholars Program at UIC fosters the development of critically reflective future clinician scholars who embrace the concepts of patient advocacy, humanism, and compassion, and blend it with the art and science of medicine. Participating students have reported the program as one of the best training experiences in medical school. This unique educational endeavor has resulted in campus-community partnerships, which are congruent with the mission of the University. It is an outstanding example of a curricular innovation that draws upon the passions and motivations of our students, the knowledge and expertise of our multi-faceted inter-professional faculty and the unwavering commitment of our community partners to create learning experiences that directly benefit patients, particularly those who are most in need of health care.

This collection of reflections is the work of scholars who participated in the program in the 2012-2017 academic years. It serves to remind us that health professions education can be dynamic and inspiring and that our learners have great insight and wisdom.

Memoona Hasnain, MD MHPE PhD
Director, PCM Scholars Program
Editor, PCM Voices

Foreword



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Editorial Assistant: Kanwal Haque, MPH

Design & Layout: Shantanu Agara Dwarakanath

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CORE PROGRAM FACULTY & STAFF

MEMOONA HASNAIN, MD, MHPE, PHD

Director, PCM Scholars Program

Professor and Associate Head, Faculty Development and Research

FASIKA ALEM, MPH (2012-2015)

Coordinator, PCM Scholars Program

CLAIRE BRIDGES (2015-2017)

Coordinator, PCM Scholars Program



M1 COMPONENT: FOUNDATIONS OF PATIENT–CENTERED MEDICINE

University of Illinois at Chicago, Department of Family Medicine

Faculty Preceptors

Maria Albright, MD
Katya Cruz, MD
Brian Dudkiewicz, MD
J. Andrew Dykens, MD, MPH
Mariya Dmytriv, MD, MPH
Evelyn Figueroa, MD
Michael Friedman, MD*
Thomas Gavagan, MD, MPH
Samuel Grief, MD
Sagina Hanjrah, MD
John Hickner, MD, MSc
Keia Hobbs, MD
Abbas Hyderi, MD, MPH
Matt Johnson, MD
Nandini Khatkhate, MD
Ariel Leifer, MD
Mykela Loury, MD
Todd Ochs, MD**
Sonia Oyola, MD
Mark Potter, MD
Nimmi Rajagopal, MD
Glenda Rios, MD
Minesh Shah, MD
Augustine Sohn, MD, MPH
Richard Stringham, MD
Jeffrey Tiemstra, MD
Patrick Tranmer, MD, MPH
Christina Wells, MD
Tabatha Wells, MD

*SAINTS MARY AND ELIZABETH MEDICAL CENTER, CHICAGO

**NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

M2 COMPONENT: SERVICE LEARNING PROGRAM

GERIATRICS CONCENTRATION

Concentration Leader: Richard Stringham, MD & L. Amanda Perry, MD (2016-2017)

Partnering community agency:

HOUSING OPPORTUNITIES AND MAINTENANCE FOR THE ELDERLY (H.O.M.E.)

Gail Schechter, Executive Director

Caren Arden-Tabani, Housing Coordinator

Lisa Leland, Shared Living Coordinator, Nathalie Salmon House

Nikki Moustafa Good Life Coordinator, Nathalie Salmon House

Tricia Mullin, Program Director

Kara Wackrow, Good Life Coordinator

HIV/AIDS CONCENTRATION

Concentration Leaders: Minesh Shah, MD and Abbas Hyderi, MD, MPH (2012-2015); Ariel Leifer, MD & Paul Rotert, DO (2015-2016)

Partnering community agencies:

EDGEALLIANCE / AIDSCARE PROGRESSIVE SERVICES

Eric Homer, Vice President

PROJECT VIDA

Andrew Roberts, Director of Care

Jerome Montgomery, Executive Director

HOMELESSNESS CONCENTRATION

Concentration Leaders: Nimmi Rajagopal, MD and Keia Hobbs, MD

Partnering community agency:

LINCOLN PARK COMMUNITY SHELTER (LPCS)

Erin Ryan, Executive Director

Linda Gibson, Housing Manager

Julia Weegar, Volunteer Coordinator (2012-2013)

Laura Kirby, Volunteer Coordinator (2013-2014)

Sean O'Gara, Program Director

Brianne Spresser, Senior Case Manager

Jen Kouba, Volunteer and Community Relations Manager



IMMIGRANT HEALTH CONCENTRATION

Concentration Leaders: Andrew Dykens, MD, MPH and Sagina Hanjrah, MD

Partnering community agency:

HEARTLAND ALLIANCE

Darwensi Clark, Manager, Resettlement and Placement Services and Adjustment and Employment

Léa Tienou, Associate Director of Refugee Family Adjustment and Employment Services

Elisabeth Hebert, Medical Case Manager

INTIMATE PARTNER VIOLENCE CONCENTRATION

Concentration Leaders: Sonia Oyola, MD

Memoona Hasnain, MD, MHPE, PHD

Partnering community agency:

CONNECTIONS FOR ABUSED WOMEN & THEIR CHILDREN (CAWC)

Stephanie Love-Patterson, Associate Director

Roxana Licon, Counselor/Advocate

Meave Raphelson, AM, Counselor/Advocate

Beatrice Burgos, Shelter Director



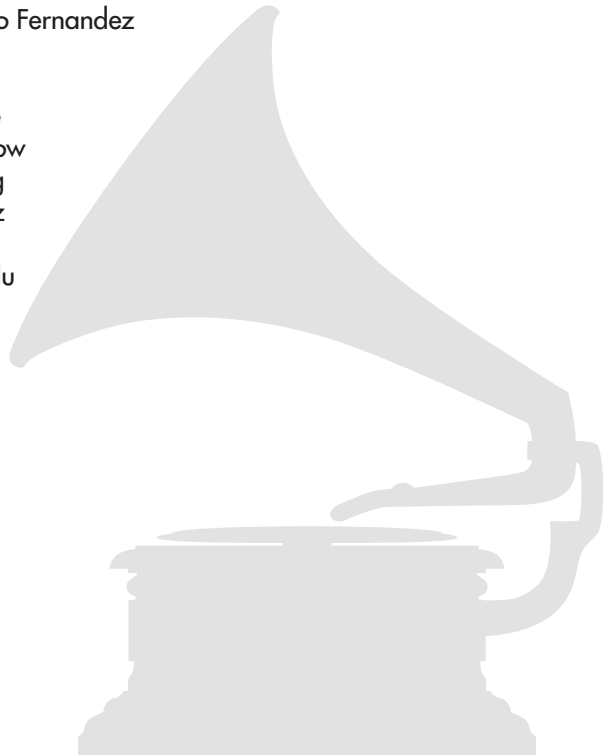
2012–2013 PCM Scholars

M1

Oluwemimo (Wemi) Adeyanju
Andrew Bellino
Azra Jaffer Bhimani
Jennifer Chertow
Jennifer Cueto
Jim Curry
Jacob Fyda
Martina Gabra
Bo Marcus Gustafsson
Anne Henson
Lauren Hughes
Alexander Kim
Eesna Bhalla
Adrian Boscolo-Hightower
Shani Chibber
Kunal Desai
Samantha Glass
Vidya Govind
Jeremy Kruger
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Roland T Njei
Cynthia Orantes
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Megha Shankar
James Swakow



Syed Alavi
Katie Kinzer
Shama Patel
Meagan Appleman
Rebecca Krasaeath
Sabrina Reed
Natalie Bodmer
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Tiffany Lu
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Jacqueline Wulu



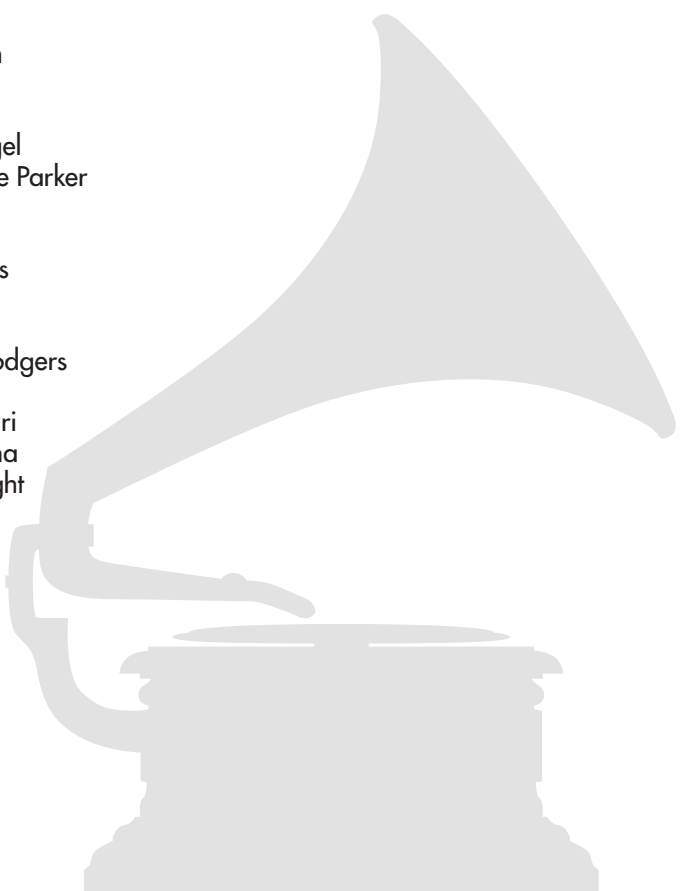
2013–2014 PCM Scholars

M1

Nikolai Arendovich
Roberto Bonilla
Lindsay Christine Boven
Nicole Bronson
Alanna Burnett
Jonathan Butts
Mamatha Challa
Devashree J Dave
Wesley Gibbert
Fatima Y. Giron Rivas
Samantha Glass

Polly Godfrey
Camdin (Caitlyn) Gray
Kimberly Helseth
Jordan Hoerr
Jason Huang
Abdisamad Ibrahim
Adham Karim
Ryan Logan
Danielle Marie Nagel
John James (JJ) Fiske Parker

Daniel Parsons-Moss
Birju Rao
Anna Ratoff
Laura Hyun-Hwa Rodgers
Joan Savage
Christiana Shoushtari
Valeria SM Valbuena
Samuel J. Wainwright
Daniel Wang
Fan (Peter) Zhu
Ivy Zhu



Oluwemimo (Wemi) Adeyanju
Kimberly Beiting
Andrew Bellino
Azra Jaffer Bhimani
Jennifer Cueto
Jim Curry
Jacob Fyda
Dani Guerrero
Bo Marcus Gustafsson
Anne Henson
Caroline Holmes
Lauren Hughes
Jeremy Kruger
Ana Clara Mauro
Samuel Muench
Roland T Njei
Cynthia Orantes
Alexandra Roybal
Monica Samelson
Shuvani Sanyal
Lauren Segelhorst
Megha Shankar
James Swakow
Ruth Anne Whitfield



2014–2015 PCM Scholars

M1

Eesna Bhalla
Adrian Boscolo-Hightower
Shani Chibber
Kunal Desai
Samantha Glass
Vidya Govind
Mamatha Challa
Amalia Hatcher
Omar Jamil
Eden Liu
Joshua Muniz
Elizabeth Nagel
Michael Ozga
Jasmine Partida
Ashley Patel
Bhavik Patel



M2

Michael A. Belmonte
Lindsay Boven
Nicole Bronson
Devashree Dave
Wesley Gibbert
Fatima Y. Giron Rivas
Polly Godfrey
Preiyaa Gopinath
Emily Graber
Jordan Hoerr
Abdisamad Ibrahim
Bryan Killian
Jeremy Kruger
JJ Parker
Laura Rodgers
Joan Savage
Daniel Wang
Samuel Wainwright
Nikolei Arendovich
Daniel Parsons-Moss

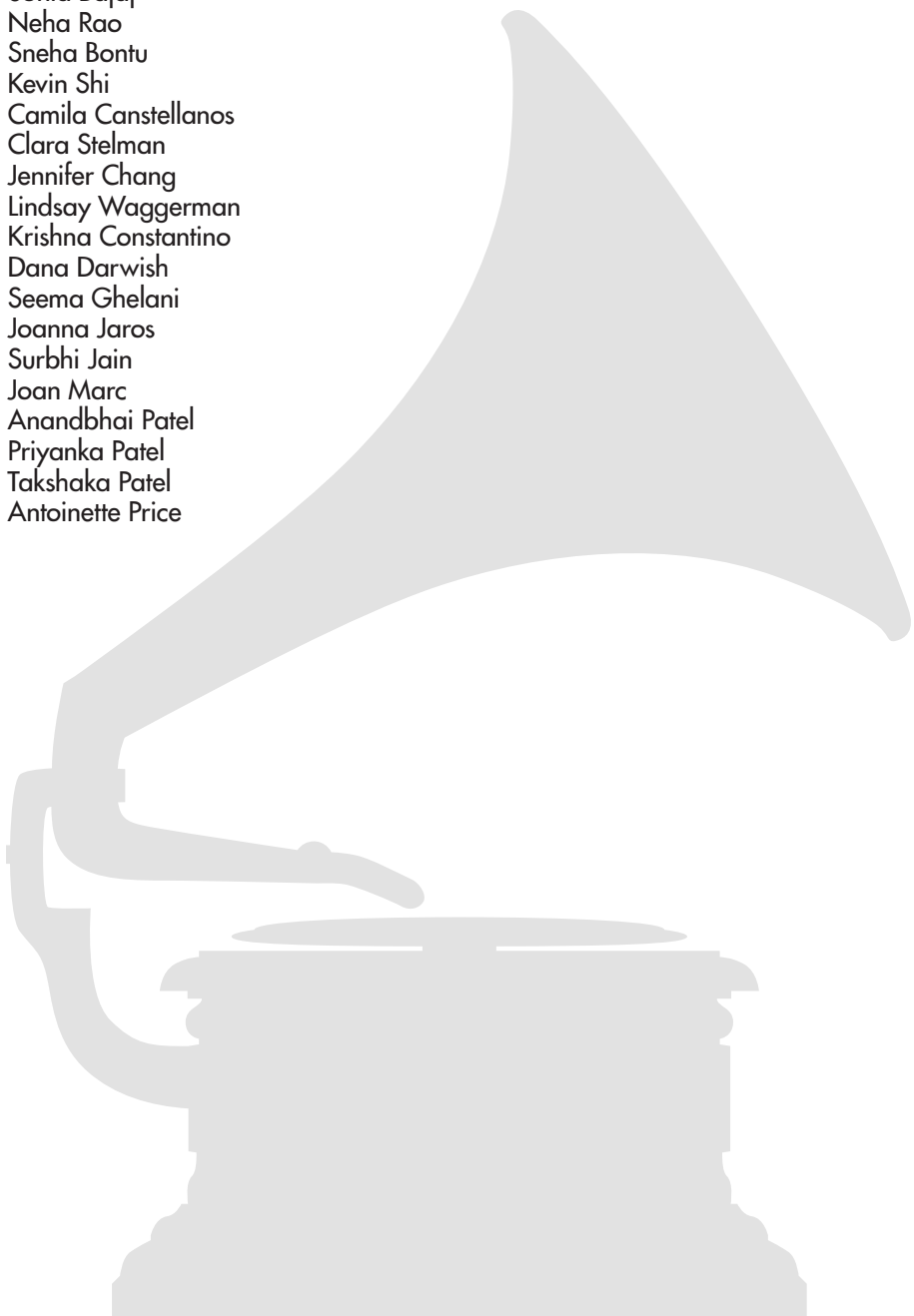


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2015–2016 PCM Scholars

M1

Faisal Akram
Sonia Bajaj
Neha Rao
Sneha Bontu
Kevin Shi
Camila Canstellanos
Clara Stelman
Jennifer Chang
Lindsay Waggerman
Krishna Constantino
Dana Darwish
Seema Ghelani
Joanna Jaros
Surbhi Jain
Joan Marc
Anandbhai Patel
Priyanka Patel
Takshaka Patel
Antoinette Price



M2

Eesha Bhalla
Adrian Boscolo-Hightower
Shani Chibber
Kunal Desai
Samantha Glass
Vidya Govind
Amalia Hatcher
Omar Jamil
Eden Liu
Joshua Muniz
Elizabeth Nagel
Michael Ozga
Jasmine Partida
Daven Patel
Bhavik Patel
Ashley Patel
Katherine Reifler
Kayla St. Claire
Rachel Tatz
Yuri Zermeno
Yuli Zhu
Nathan Lin
Divya Verma
Katherine Venegas



Acknowledgements

2016–2017 PCM Scholars

M1

Neharika Akkoor
Samara Albazzaz
Taylor Burch
Jissy Cyriac
Claire Daniel
Rosa De La Torre
Mallory Hawksworth
In Ae Jang
Kaitlyn Lapen
Patricia Lee
Anjella Manoharan
Mark McArthur
Hansika Narayanan
Tamara Nunez
Andrew Ormseth
Alicia Pugh
Ravand Samaeekia
Sofia Sami
Isabel Sanchez
Parth Savsani
Monica Sharma
Zainab Shirazi
Melissa Socarras
Rebecca Steuer
Ivana Surjancev
Justin Temple



M2

Faisal AkramAhad
Bagasarawala
Rachel Bervell
Sneha Bontu
Jonathan Cedermaz
Jennifer Chang
Krishna Constantino
Dana Darwish
Pyone David
Christina Du Breuil
Addis Enyew
Maria Gomez
Nohemi Herrera
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Alan Jarman
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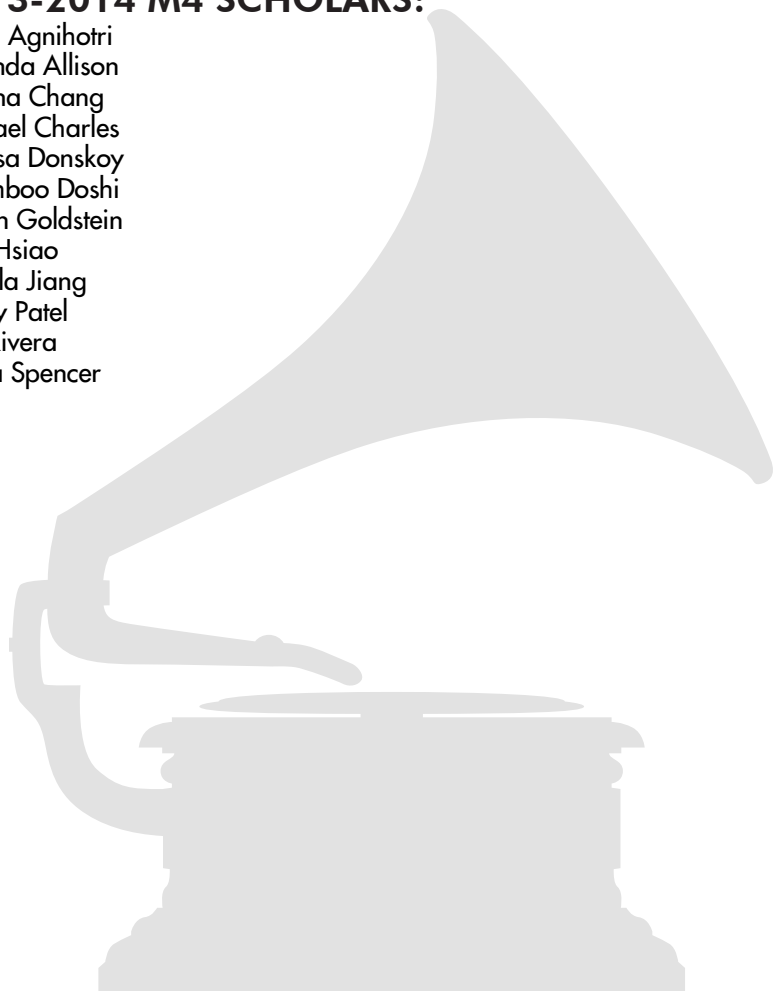
M4 COMPONENT: REFLECTIONS ON PATIENT-CENTERED CARE**

2012-2013 M4 SCHOLARS:

Osamah Abdallah
Benjamin Carney
Celeste Cruz
Carmen Flores
Rachel Guild
Dempsey Hughes
Anne Jennings
Lauren Kendall
Jade Pagkas-Bather
Melissa Preyss
Laurine Tiema-Benson

2013-2014 M4 SCHOLARS:

Neha Agnihotri
Amanda Allison
Edwina Chang
Michael Charles
Innessa Donskoy
Khushboo Doshi
Aaron Goldstein
Ruth Hsiao
Angela Jiang
Sonny Patel
Luis Rivera
Jenna Spencer



INTERPROFESSIONAL APPROACHES TO HEALTH DISPARITIES SCHOLARS (IAHD)

2014-2015 IAHD SCHOLARS:

Mustafa Alavi	College of Medicine
Darcy Benedict	College of Medicine
Viola Bockenfeld	College of Pharmacy
Natalie Bodmer	College of Medicine
Ann Bruno	College of Medicine
Brenda Burke	Nursing- DNP-Executive Nurse Leadership
Carolyn Dewart	College of Pharmacy
Rebecca Frale	Jane Addams College of Social Work
Jessica George	College of Medicine
Katherine Jahng	College of Pharmacy
Heu Yeon Kim	College of Pharmacy
Jessica Kuppy	College of Medicine
Jennifer Sue Lee	College of Pharmacy
Hung-Chun (Joel) Lin	College of Pharmacy
Tiffany Lu	College of Medicine
Yijia Luo	College of Pharmacy
Jody Mallicoat	College of Pharmacy
Jose Marquez	College of Medicine
Leslie McDavid	School of Public Health
Kellyn Moran	College of Pharmacy
Erika Olson	College of Medicine
Christina Pate	School of Public Health
Shama Patel	College of Medicine
Sabrina Reed	College of Medicine
Jasmine Shah	College of Pharmacy
Jacob Sicinski	College of Pharmacy
Rhonnie Song	College of Medicine
Jonathan Williamsen	Jane Addams College of Social Work
Jacqueline Wulu	College of Medicine

Acknowledgements

2015-2016 IAHD SCHOLARS:

Wemi Adeyanju	College of Medicine
Kimberly Beiting	College of Medicine
Jacob Fyda	College of Medicine
Dani Guerrero	College of Medicine
Ann Henson	College of Medicine
Nichelle Hickland	School of Public Health
Caroline Holmes	College of Medicine
Lauren Hughes	College of Medicine
Bryan Killian (M3)	College of Medicine
Jeremy Kruger	College of Medicine
Ashley McKinney	School of Public Health
Samuel Muench	College of Medicine
Roland Njei	College of Medicine
Cynthia Orantes	College of Medicine
Shuvani Sanyal	College of Medicine
Ann Schraufnagel	College of Medicine
Megha Shankar	College of Medicine
Jim Swakow	College of Medicine

2016-2017 IAHD SCHOLARS:

Lauren Abdul-Majeed	College of Medicine
Nikolai Arendovich	College of Medicine
Michael Belmonte	College of Medicine
Mamatha Challa	College of Medicine
Devashree Dave	College of Medicine
Wesley Gibbert	College of Medicine
Bryan Killian	College of Medicine
Abdisamad Ibrahim	College of Medicine
JJ Parker	College of Medicine
Daniel Parsons-Moss	College of Medicine
Daniel Wang	College of Medicine
Ivy Zhu	College of Medicine

IAHD PROGRAM FACULTY 2014–2017

Susan Altfeld, MA, PhD	Public Health
Ron Chacko, MD	Medicine
Andrew Dykens, MD, MPH	Medicine
Valerie Gruss, PhD, APN, CNP-BC	Nursing
Sagina Hanjrah, MD	Medicine
Memoona Hasnain, MD, MHPE, PhD	Medicine
Keia K Hobbs, MD	Medicine
Michael Koronkowski, PharmD	Pharmacy
Sonia Patricia Oyola, MD	Medicine
Laura Amanda Perry, MD	Medicine
Nimmi Rajagopal, MD	Medicine
Minesh Shah, MD	Medicine
Richard Stringham, MD	Medicine
Naomi Twigg, PhD, PHCNS-BC, RN	Nursing

Acknowledgements





musings on
becoming a
physician



M1 PCM Scholar Reflections

Shared Humanity

I walked in, as clueless as can be
What did I know about how to care for a human?
She walked in, with her trusting eyes
She'd survived many struggles
Breast Cancer to Shingles, she had withstood the worst kind of pain

The room was white, just like my coat
In a pale white setting, walked in the Doctor,
My preceptor, to perform his role
So easily he drifted about the room
So at ease he put me and her with his presence.

In her own language he spoke to her,
From physical exam to ordering tests, he carried them out
So kindly he spoke to her, sharing his life stories with her as much as she did
with him,
She talked frankly because in him she saw honesty,
She was already feeling better by the time she walked out.

I learned that the power of white coat was more of a privilege
It allowed an entrance through a person's most guarded gates,
And it was the easiest of tasks,
I didn't have to pretend to be a God or a fairy,
Because all it requires to care for a human,
Is to let the patient see,
Just like her, I too, am only Human.

Devashree Dave
2013-2014 M1 Scholar



Communicating Experiences

Can you feel it coming?
Racing, tracing a path through
Lately... it's hard deciphering what's true

Excitement bubbles over
Things to do people to see
Let's go conquer the world you and me

All that's needed is
Hard work, a good plan
Already have a good man

But, somehow...
What was simple has become complex
What to do with these unwanted side effects...

Bright lights, linoleum floors
Once more it has come to this
Once more everything seems amiss

--

She's prepared with appointment dates
Enthusiastic to greet what waits
No one would know of her struggles

I don't know what to expect, nervous
But eager to be of service
I ask question after question

With the questions, answers came hand-in-hand
Reliability, confidence, someone who understands
That's what a patient desires from a doctor

Therefore, I'll keep this well in mind as I undergo
the process of becoming a physician and will forgo
Biases and assumptions to become a physician to whom a patient can relate

Wemi Adeyanju
2012-2013 M1 Scholar

Gospel Chops

The best part of Patient-centered Medicine (PCM) Scholars program is that you get to treat people! Imagine that. Real live people, who usually have more going on than just the symptoms they present. Some of them even have their own ideas, dreams, passions, and stories. Being a PCM Scholar has afforded me extraordinary opportunities to meet with and interact with patients, but also to get to know some of them as real people. I'd like to tell you about one of them.

Patient JB is a 40 y/o African American male who presents to our clinic with a history significant for an admission into the ER for palpitations, chest pain, and anxiety 3 months prior to arrival. After being worked-up to rule out an MI by lab tests and a 12-lead ECG, he was diagnosed with anxiety. He has since been unable to work and undergoes weekly therapy sessions. The patient presents to the family medicine clinic looking for some paperwork to submit to his disability benefits case worker.

JB came into the clinic on my second visit, accompanied by his wife and 4-year-old boy. During the patient interview with my preceptor his little boy grew a bit restless, so we excused ourselves to let the grown-ups talk while we went on an adventure in search of stickers. The mission was a great success as we were able to get some sweet Spiderman stickers and the doctor was able to help JB with his paperwork troubles.

Unfortunately, I missed most of the patient interview, so my preceptor took his wife and son out to pick up the paperwork and I was given the chance to talk with him one-on-one. On interrogation, he revealed to me how this all started at work about 3 months ago. He was suddenly overcome with a gripping chest pain and he felt dizzy, his thoughts were racing. His concerned co-workers insisted he go to the Emergency Room, and that's when all the trouble began. You see, in the emergency room, they ran all their fancy tests and found out there was nothing wrong with him, therefore there was nothing to treat and he was sent on home. And home is where he's been ever since.

In spite of medications and therapy, he hasn't been able to return to work. He was assigned different case managers for his insurance and disability benefits, and none of them seemed capable of coordinating what he needed. The weekly therapy was helping him to control his emotions and avoid becoming overwhelmed. His days consisted of sitting at home all day, watching TV and playing videogames, biding his time until he could return to work. As a first-year medical student, I'd be lying if I didn't find myself a bit jealous of his predicament, so I investigated further.

"What kinds of foods do you eat?" "Nothing much", he responded. He had lost nearly 30 pounds over the last 3 months. Food to him had lost much of its appeal. He couldn't even eat a big juicy steak his wife had prepared for him a few days prior because he couldn't derive any pleasure from the taste. At this point, I'm starting to appreciate the full weight of the situation. If this man can

no longer derive pleasure from delicious steak, there must really be something wrong!

I pressed further, "What sorts of things do you normally enjoy doing?" Turns out he was a drummer for his church. Gospel chops! As a drummer and a music lover myself, I knew the kind of talent I was working with here. We spent the next 10 minutes talking about electronic and acoustic drum sets, music, and gospel until my preceptor returned. "We'll have you back working on those gospel chops in no time," we assured him.

JB returned two weeks later:

Patient JB is a 40 y/o AAM with PMHx significant for anxiety who presents to this clinic for follow-up of his anxiety treatment. Patient reports apparent relief of his anhedonia and lethargy. His food intake has increased, and he reported really enjoying a steak meal 2 days PTA. Patient has begun exercising and sees his weight loss as an opportunity to get into shape and has started exercising regularly. He is back to playing drums in his church, has been working on his gospel chops, and looks forward to returning to work full-time, next week.

Jonathan Butts

2013-2014 M1 Scholar



First time

No more pre-tied ties?
But now I must improvise.
YouTube rescue me!

Mistakes

Stethoscope in ears,
Deep breathe in. Deep breathe out, please.
Over scapula.

Death

Close family history,
Small tears rolling down his cheeks.
Mom was dearly loved.

Vacio

Esposo. Papá.
El vacío desorienta,
preguntas difíciles.

Jacob Fyda
2012-2013 M1 Scholar



A Funny Feeling

I had a wonderful experience with the Patient-centered Medicine (PCM) Scholars Program this year, but not quite in the way I had expected going in. I walked into my pediatrician preceptor's office expecting to follow a patient for the duration of my academic year, but that never happened. I met Michael, and he was a great kid with a really intelligent mother, but I was never able to reach her by phone or email after the initial encounter. She was, my preceptor offered, a very busy and competent mother, and was able to navigate the medical system without having to rely on a medical student learning his own way through the system.

So, my clinical visits involved my coming to my preceptor's office and visiting with the patients that came in, and I always had a funny feeling going in. I felt funny because I would spend my 40-minute bus ride going over OLD CARTS or reviewing the review of systems and making sure I had all the basic interviewing procedures down. I felt funny because I came in expecting to have to practice the core competencies, they teach us in ECM, while my preceptor teased me for dressing so properly. This is a peds clinic, after all. Second semester he ended up giving me a bag full of ties, with designs including Peanuts, Mickey Mouse, and Looney Toons. I wasn't able to bring the same warmth to the clinic that he exuded as I tried to keep track of all the important past medical history questions. I felt funny because while I knew my preceptor wanted me to gain clinical experience, I also wondered if he thought I was being too serious.

Where does that put me as I continue to train to be a doctor? I really don't know. I wonder when I'll feel competent enough with the science of medicine to begin to feel comfortable doing the art side of things. I wonder if I'll figure out how to practice the two together. But I do know that my preceptor was a brilliant example of what patient-centered medicine is all about. I loved that he saw in me enough interest in pediatrics to give me a bag of fun ties. But I loved how much he cared for everyone else, too. When I asked him what he got for Christmas, he told me his present was giving two kids a bike—and then giving one to their grandmother to boot. He talked incessantly of his daughters, all of whom he and his wife adopted from China. And he lent me his favorite book on medical “care” in Nazi Germany because he felt that doctors asking important “why” questions throughout their development and careers is a priority.

I've learned how much I don't know, about medical science, about navigating the healthcare system, and about building rapport with patients during my experience in PCM this past year. But I have a funny feeling that if I can follow my preceptor's example and start on the inside in putting the patient at the center, I'll eventually get there.

Jordan Hoerr
2013-2014 M1 Scholar

PCM 101 Song

DM7 E6
I'm putting on my white gown today
Bm7 AM7
Gonna visit the clinic I say
DM7 E6
With a PCM form on hand
Bm7 AM7
And a list of OLD carts I have planned

F#m AM7
How are you today?
Bm7 E7
Is there anything I can do to make things okay?
F#m AM7
Tell me where it hurts?
Bm7 E7
Did I miss anything in OLD carts?

Now, Imma ask you some sensitive questions
Don't have any creepy intentions
No worries I won't tell anyone
But when's the last you had some sexy fun?

Man, this feels so awkward
What does sexual activity have to do with your GERD?
But I have to ask
I need to take this info and write a complete Hx...

After a few grueling sessions
I sit down for some inner reflection
These small words and interactions
I know they'll make me gain some traction

In the world today
Communication seems to be on the delay
Through the PCM program
I've learned critical skills, it really isn't a sham

Take into account
The unique number of patients is a great amount
I can't hide the excitement
We'll need to make an equal number of custom treatments

Now, the program, is done
It really was a lot of fun
Patients are people with needs and cares
So, it truly is important, we need to declare!

Alexander Kim
2012-2013 M1 Scholar

Medicine: A Personal and Professional Commitment

From the very first day of medical school, and even as far back as in our premedical education classes, we have been taught to think critically and astutely. Categorizing and compartmentalizing data and material accordingly, in hopes of becoming efficient students, effective learners and, one-day, physicians. However, growing up as an underrepresented minority I learned early on that life is not always black and white. That in fact there are many shades of gray. I was reminded of this when I met my patient; a sixteen-year-old boy from a single parent household, who was born into a life with circumstances beyond his control.

During our initial meeting, I could tell my patient was apprehensive and shy, as any sixteen-year old boy would be. However, as our meeting progressed, I could tell from his expression that he wanted an outlet. Putting myself in his shoes, I was more than willing to be there for him in any way I could. While I cannot do much to change my young patient's circumstances, I can however provide him with my time to ease his pain and suffering.

I am grateful for the PCM Scholars Program because it has introduced me to my patient and granted me the opportunity to work with my mentor. In the chaos of medical school, this experience has been a breath of fresh air as well as a reaffirming step for why I chose medicine. My time in the clinic alongside my preceptor has helped provide me with the necessary knowledge and tools to build a relationship with my patient, collaborate with them in their decision making, and coordinate their route of care. However, most importantly it has provided me with an avenue to better communicate with my patient. My involvement in the program has strengthened and informed my professional philosophy. I am adamant that the medical field can be more than the provision of health care services; if one is willing to make a personal and professional commitment to the people they serve.

Cynthia Orantes
2012-2013 M1 Scholar

Before I started medical school, I participated in the health care process as a patient or relative of a patient. It was only after I started medical school that I saw the health care process from the side of the provider. I was particularly interested in working with geriatric patients because I have personal experience watching my grandparents adapt to their declining function. As my grandparents' physical and mental health continue to deteriorate, my father and his siblings have worked with physicians, social workers, nursing homes, and insurance companies to manage their care. Now, as a PCM scholar, I have seen first-hand the role of the physician in helping families coordinate these subsets of health care.

My preceptor at the geriatric's clinic epitomized the role as manager of integrated care and patient-centered medicine. Her goal was not necessarily to extend life, but to prolong functioning capabilities and patient comfort. This goal requires more than just a 15-minute session. It requires in-depth conversations with the patient and their family to determine the patient's wishes and how best to accomplish this. The relationships my preceptor fostered with her patients was clearly evident in their beaming smiles and enthusiastic greetings when she walked in.

It was hard at first to see geriatric patients come to the clinic because modern medicine does not have the cure for aging. All the physician can do is alleviate the symptoms of aging and provide resources to manage symptoms that cannot be controlled. Yet this role is as important as the surgeon or the ER doctor. Geriatric patients often have declining mental as well as functional capabilities and our job is to ensure that they continue to be treated according to their wishes.

The difficulty in this field is that some geriatric patients do not have the mental capabilities to make their own decisions and so this role falls to families who may be unsure what is best for their aging parent. As an example, a family may decide that the best course is to put their parent in a nursing home where they can receive full-time focused care. This decision can be fraught with guilt as the children making this decision may be going against their parent's wishes. Physicians can help alleviate this family struggle by working with social workers to develop a plan that not only is best for the patient's health but also for their emotional and mental stability.

Laura Rodgers
2013-2014 M1 Scholar

Growing into the Role

The path to becoming a physician is one that is filled with paradoxes. I appreciated this on my first day meeting and shadowing my PCM preceptor. Painfully aware of both the responsibility awarded us as medical students and the common perception that we are young fledglings incapable of shouldering any, I chose my appearance with care. Black unassuming slacks, professional-brown eyeliner – should I add some wrinkle lines? Which shirt says “sincere” best? In all seriousness, the fear that I would be perceived as a puddle of nervous naivety was a real one. How was it possible that patients would call me “doctor” one day?

It feels very strange to be a member of a profession where the best teachers are those whose lives the students will one day hold in their hands. The journey from M1 to doctor involves a role-play of confidence and authority where some patients assume you are licensed and ready and some refuse to speak to anyone but the “real doctor”. In practicing taking an HPI, we pretend we know what questions to ask; in recording a sexual history, we must put on a face of stoic professionalism while underneath we might be cowering; in measuring blood pressure, we try not to fumble with the patient’s arm and expose ourselves as amateurs. And after all this play-acting, we always say “Thank you for talking to me – the [‘real’] doctor will be in shortly.”

It was my PCM patient that showed me the deeper and more significant value of these interactions. She let me practice taking an HPI with both an air of respect for me and an understanding of my fledgling status. As I transitioned into the full history, however, the role-play quickly transitioned into a simple conversation about her life. Her candidness resulted in an effect of mutualism: the more she opened up, the more I felt she saw me as a real person with real cares and sincerity, and the less I felt like an actor playing a role. The effects this shift in perception had on my future visits and blossoming relationship with my PCM patient were manifold. I began to see the real value of practicing skills such as taking an HPI, and soon these role-plays stopped feeling like barriers between myself and the patient. It wasn’t long before I was having real and powerful interactions with almost every patient I interviewed.

Among the numerous lessons I’ve learned in PCM Scholars Program as an M1, one of them has caused me to feel quite different when I wake up before clinic visits now. In getting to know my PCM patient, I was not only blessed with the presence of an amazing woman of great strength. When I put my white coat on these days, I don’t feel like I’m playing dress-up, but rather that I’m a future physician capable of forming lasting relationships with patients based on mutual respect. That is a gift of immeasurable value, and I look forward to the years to come with anticipation.

Monica Samelson
2012-2013 M1 Scholar



Motivation

So many exams
Endless nights of studying
Wondering the purpose

Of all the hard work
With even more tests to come
But the hardest one

The most important
Asks a harder question than
What's a Broca's aphasia?

We have to connect
To patients in front of us
More than their illness

We have to learn how
To understand their fears, joys
Concerns, history

These connections,
Integral to patient care,
Hard to establish,

Harder to maintain,
Are worth every effort
As motivation

To continue on
This long and arduous road
Towards an MD

Samantha Glass
2014-2015 M1 Scholar

I entered medical school knowing that I wanted to develop into a kind and compassionate physician. Though many of my academic goals morphed and adapted during the past year, this experience remained a grounding constant. I expected to learn a great deal about the logistics of practicing patient-centered medicine through my preceptor, but I was truly humbled by how much I learned about the role of vulnerability and trust in health outcomes from my continuity patient.

I was enthusiastic, to say the least, during our first meeting. Her calm and collected demeanor immediately reminded me that our relationship was not at all about my excitement to be a real, contributing member of her healthcare team but completely about her experience as a chronically ill patient. Thus, I was nervous when we faced a two-hour wait for our first appointment together. She wasn't eager to open up to me, a new medical student who barely knew what all the words on her chart meant. However, after some comforting small talk, she suddenly shared the most intimate details of her adult life and health issues with me. I sat with her in tears, stunned by how well she had initially hidden her desperation to share her fears and hopes with someone, and humbled by the extent of her trust. Soon, she was asking me questions about how she could more proactively quit smoking and improve her diet to accommodate her unique nutritional needs. We both left that day with a renewed sense of determination to improve her health.

Being a PCM Scholar has helped me remember the magnitude of my privilege as a medical student and future physician. Patients come to their health care providers in extremely vulnerable states, and I am truly grateful to have had the chance to work on developing myself into a physician worthy of such great trust.

Vidya Govind
2014-2015 M1 Scholar



Time is of the Essence

"Don't waste my time. I don't wanna see a medical student if they're going to waste my time."

-Patient

Well, this certainly doesn't set the stage for a favorable encounter. Yet, I walk into the room bright eyed and bushy tailed, pearly white coat on, new sweater my mom bought me for my first clinic visit. It's like the first day of school all over again, excited to meet people and learn their whole story. Yet, now it's no longer waiting for when lunch bell will ring but rather it's my job. It is my occupation, my calling to serve my patients. I have the opportunity to serve them when they are excited to see me, annoyed, or any remote feeling in between. I walk in and the game is on.

The game begins just like any other, with the first level which is largely an introductory preface. The patient converses with me, reluctantly at first, and expresses the reason for the visit today. There is a palpable level of anticipation for the patient, waiting for the moment when they learn what can be done for them today and when they can actually see the 'real' doctor. Nonetheless, it is my time as a medical student to really get to know the patient and gather a thorough story. And this is the part that is most exciting to me. Learning the ins and outs of the disease process, both pathological and emotional, behavioral, etc. It is a giant jigsaw puzzle, one that cannot be solved with my head in a book or pressed against a screen. I need to actually talk to the patient and learn from the patient. This is the art of medicine, the stuff not necessarily taught in Ross and Paulina's histology book. This is the good stuff.

The visit continues as I feverishly implement information into the rather cluttered Cerner arrangement. I apologize for the need to type into the computer as I've seen my preceptor use before and the patient appreciates this. The patient understands the necessity of the EMR but appreciates the thought. I utilize a little humor in the visit, crack a smile in the patient, and we are home free. Information gathered, ready to present to my preceptor, and all is well. Did I waste my patient's time? Sure, the visit took a little longer in duration, but I gathered a more complete history, established and built rapport, and even cracked a joke in there to make the patient feel more at ease with the situation. Time is certainly of the essence but there is no replacement for creating a strong physician-patient bond. That is what patient centered medicine is all about and I have been able to see that throughout my experience in the PCM program.

Michael Ozga
2014-2015 M1 Scholar

Illness can be frightening to most
Especially when diagnosed.
But show you care,
And don't be bare,
Then patients will share the utmost.

Sneha Bontu
2015-2016 M1 Scholar

Musings



We Speak with Our Eyes

As a physician you are engrossed in the million little checklists you have made. Everything you need to do. What you need to say. What you need to collect. There is a moment where the patient's reaction is forgotten. When in reality, the patient's words do not mean anything, what you collect does not mean anything, if their eyes say something else. Focus on their eyes

"We're running a little late"

Anger

"I apologize, how long have you been waiting?"

Impatience

"So, tell me what brings you in"

Hesitance

"Tell me more about yourself"

Relaxation

"What do you want?"

Curiosity

"What are you worried about?"

Fear

"Why haven't you been taking your medications?"

Defensive

"Let's do what you came in for today"

Trust

"We'll figure something out for you"

Relief

For they tell you everything.

Dana Darwish

2015-2016 M1 Scholar

As first year medical students, our lives always feel fast paced. We're racing around from class to hospital visits. We're trying to make time for the gym, friends, and family. We're all overachieving perfectionists who spend most of our time studying and trying to do our best on exams. By the time we get home at night, we're asleep and doing it all again before we even get a chance to catch our breaths.

So, when I first was assigned a preceptor that took me forty minutes to get to, I freaked out. How was I going to go there, spend a day learning, come home, and study again? How would I give everyone my full attention while in the back of my mind I was stressing out about everything I had to be doing?

Almost immediately upon my first visit, these anxieties and worries faded away. Some of these patients traveled over an hour to get care. Many of them had multiple doctor and specialty visits a week. And my preceptor gave every single patient his full attention and time. Sometimes we would be in a single patient's room for forty-five minutes, just listening to what was going on their life or what was worrying them. One particular Saturday, we were running almost 2 hours behind, but my preceptor stayed the full 2 hours after his office closed to spend time with his patients. He never rushed them out the door or let on how stressed he was, he let every patient tell their story. And after we finally finished over two hours later than expected, he still went to the hospital to go check on a newborn. Even though doing well in classes and studying for tests was important, it just seemed so much less important than spending time with patients and hearing their stories.

One particular morning when I was accompanying a patient, I was working with longitudinally to her specialist appointment, I began to really understand the sacrifices and lengths some patients go for care. I met with the patient and both her parents at the spinal bifida center, and they were perky and telling me about their lives and their four kids. Both parents had taken the day off work to come to this appointment because they were concerned about their little girl, but they never let on. Both the patient's family and I had traveled quite far to get here, but we chatted and waited happily for thirty minutes for the appointment. Finally, they called us up and to our anger said we couldn't go in today. The insurance needed to be put through for the test a week in advance, so we'd have to go send the information to the insurance company and come back in a week. I was so frustrated; wasn't there ANYTHING they could do to speed up the process? We had to wait seven whole days for a test the patient needed? And why had no one said anything about this before traveled all this way to get here? Their girl needed this test. Both parents skipped work, which they needed to pay for these medical expenses and their kids. It was half a day just completely wasted.

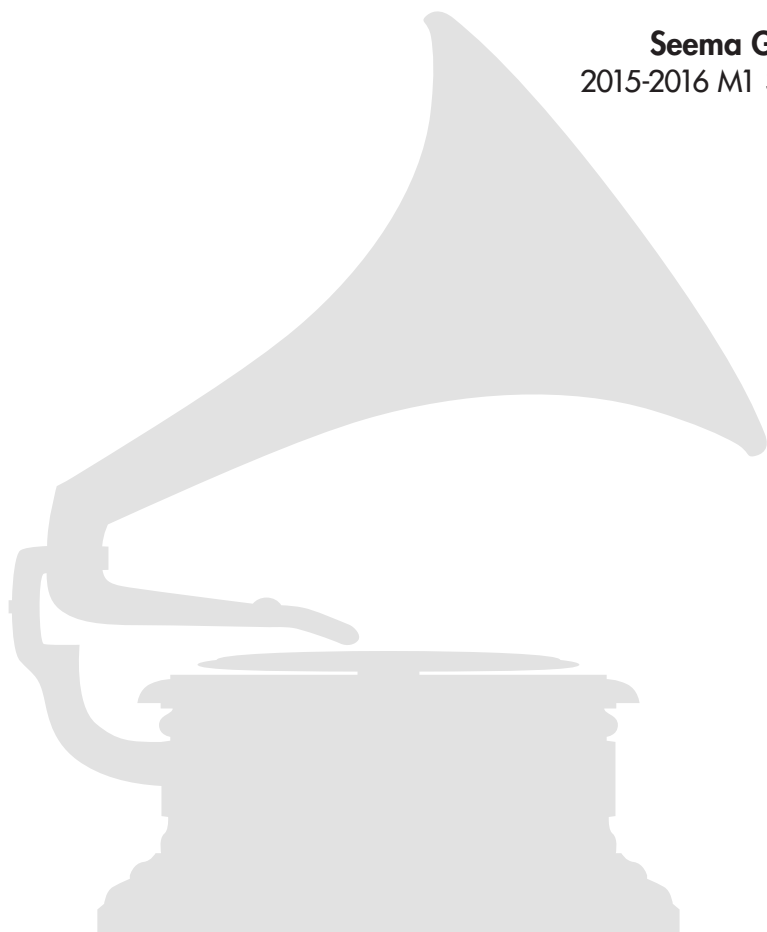
The next week when I was back at the preceptor's office, this family came in for one of their primary care visits. I had told my preceptor what had happened at the specialist's office last week, and I expected the patient's family to bring it up during their appointment since he was the one who referred them. To my surprise, they never said a word. Yet they still hadn't been able to get the test yet! This patient encounter taught me so many things. First, often times patients feel



like they're overreacting or burdening you with unnecessary information. As the physician, it is truly your job to question your patient beyond the basic complete history questions. To show them you care. To really get to know your patients, their struggles, and a full picture of what they're dealing with is what will allow you to treat them to the best of your ability. Second, if you as the physician don't take the time to ask your patients the proper questions, or follow up with specialists, big things could be missed. If we did not find out that this patient hadn't gotten their test, it would have been so easy to assume everything was fine and there was nothing to worry about. Finally, some patients will openly share their stories and struggles with the physician, but others need a feeling of trust and a relationship with their physician to speak up. If we as medical students, or later physicians, are too busy worrying about all the little things we have to do and rushing through appointments, too much will fall to the wayside.

Our participation as PCM Scholars signifies our commitment to our patients and putting our patients first. Of course, exams are important. Making time for the gym and friends and family is important. But if we take the time to really listen to and learn from our patients, establish a relationship, and make much more informed treatment decisions with our patients, these actions will help us become the type of physicians our patients truly need.

Seema Ghelani
2015-2016 M1 Scholar



Reflections of a Future Caretaker

Discovery

I was given an opportunity to learn about medical resources for patients.

Exploration

I did not just learn facts, but I also learned how to apply them. I used what I learned from the program, and I tried to see it in the clinic. I asked myself more questions about the level of care given to various patients and I tried thinking about solutions. I obtained a foundation of knowledge that allowed me to ask my preceptor questions that I would have never thought about asking.

Sensitivity

After learning about the different perspectives found in patients of various cultures, I was more careful about my words and reactions during patient encounters. I became more thoughtful while I took an HPI, and I provided comforting words. This is difficult because of the boundaries that exist between patient and caretaker, but there is an emotional component that brings patients into the clinic that should be addressed, although put in perspective when looking for the therapy to treat the physical symptoms that brought them in. Patients need to know that we are a team; and in order for that to happen, the patient needs to trust me and feel respected.

Jasmine Partida
2015-2016 M1 Scholar



Being a part of the PCM Scholars Program, has been an amazing experience. As I reflect on the day that stands out most in my mind, a slight grin turns into a small smile. It was the day of my first ever pap smear! I had watched my preceptor perform them a number of times, and that day she subtly hinted to me that I was going to perform this one. I missed all obvious queues because I just couldn't believe that she trusted me enough to do this. I was nervous yet excited. My preceptor prompted me with questions as to what I would do for each step of the process, and to my surprise I remembered each step. In the back of my mind I kept thinking... "Don't hurt the lady...be gentle... be precise... you got this...do you have this...I can't believe I'm doing this...Oh wait why is there blood...did I do something wrong?" I look up at my preceptor like a little kid that has just made a mistake, and she instantly reassured me "oh it looks like she has a friable cervix. You are doing a great job Mrs. X and so are you Antoinette." A sense of relief came over me. At the end of the day, I went home high off of excitement, and I knew then that it was these experiences that made the grueling long nights of studying well worth it. This experience fueled me for the rest of the week. I just couldn't wait to get back to clinic. What a privilege. I am on my way to becoming a doctor.

Antoinette Price
2015-2016 M1 Scholar



Reflections

As first year medical students, we are bright-eyed and eager to learn. Proudly wearing our white coats and nervously introducing ourselves to patients, we are excited for this journey to begin. At this stage of our medical education, we spend more time in the library and lecture halls than in clinic. But as I draw out the tracts of neuroanatomy, I cannot help but think of patient care as a distant dream, only vaguely related to the complex biochemical pathways found in my textbooks. At the beginning of my M1 year, I knew that classes and clerkships would allow me to learn the precise science of medicine. But the art of healing patients—building trusting relationships, learning about patients' values and interests, and integrating treatment plans with patients' preferences—is an essential skill that can only be taught through observation, experience and reflection. I chose to participate in the PCM program to experience patient-centered medicine from a physician's perspective and learn how to develop trusting relationships with patients.

The complicated nuances of patient care became apparent each time I walked into a patient room with my PCM preceptor. My preceptor has been seeing some of his patients for over ten years, and their comfort is palpable. They tell him about their children, grandchildren, nieces and nephews, and he listens. With new patients, he would take some extra time trying to get to know them, to understand who they are. Although there are 10 other patients to see, plus charts to review and notes to write, my preceptor always takes the time to listen to his patients. For me, this is a critical aspect of patient-centered medicine—listening to patients.

A new patient once presented with classical symptoms of bronchitis, and she briefly mentioned during the complete history that she was stressed. Towards the end of the patient interview, my preceptor followed up on that comment and asked the patient if she had any ways of relieving stress, or anyone to talk to. She opened up more and told us how she had been very anxious and upset lately due to be a single mother working two jobs. My preceptor talked to her for some more time, encouraging her to handle her stress in a healthy way, and asking if she'd like to see a clinical psychologist or psychiatrist. What I thought was an offhand comment about stress turned out to be a miniature plea for help, which my preceptor immediately picked up on. This is just one example of the art of medicine in practice—throughout the year, I witnessed countless similar interactions. To establish a trusting relationship, it's vital that physicians genuinely care for the well-being of their patients and pay attention to small signs and comments. Physicians must develop an attitude of respect and humility toward patients, and this attitude is an underlying theme in patient-centered medicine. My preceptor exemplified this well, and I'm thankful for the opportunity to observe patient centered medicine in action.

Whenever I went to clinic and waited to meet my PCM preceptor, I'd be mentally preoccupied with physiology or anatomy. But the minute we stepped into a patient room together, the complexities of patient care would take over. Taking a break from classes and basic science to observe the art of patient care was always an



incredible experience, and a great reminder of why I chose to pursue medicine in the first place. As I progress through medical school and residency, gaining more knowledge of pathology and honing clinical skills, I hope that I always practice key principles of patient-centered medicine: listening carefully and staying humble.

Neha Akkoor

2016-2017 M1 Scholar



To Know

To know that you want to help others; that is the first step.

To know that to help others, you want to become a physician; that is the second step.

To know how to jump through the hoops to get your MD; that is the third step.

To know how to help your patients; well, that's just the next step, right?

Before:

Coming into this first year of medical school, I have a pretty good picture of who I am, and I know what kind of physician I want to become. I've made it into medical school after all; I must be doing something right. This PCM program seems like a natural fit for me, and the message seems simple enough – form a collaborative relationship with your patient – no sweat. After all, I have worked with underserved populations before, and I know what to expect. We'll talk for a little while, I'll know what to say, and we'll reach that positive health outcome. I got this.

After:

Wow - how little I know. It turns out, when an incoherent patient comes into clinic at the end of the day, his story confusing and unclear, and he has no shelter for that bitter cold night (or the foreseeable future), I don't know what to do. Or when a patient desperately seeks pain meds after a car accident but has a history of heroin use, I don't know what to do. Or when a patient sees no connection between their health problems and their alcohol and tobacco use, I don't know what to do.

I spent a year getting to know my patient and other patients at the clinic. Do I know that I have helped them? Do I know what to do in a 15-minute appointment when my patient has a laundry list of concerns? Do I know how to completely drop my own judgments and check my privilege at the door as I knock on it to see a patient? No.

However, what I do know is that I don't know. And after all, maybe that is the first step.

Mark McArthur
2016-2017 M1 Scholar



It is well known to every applicant of medical schools that having great scores on your transcripts and standard tests will not grant you an admission. A crucial aspect of the application and interview process is related to the experiences gained in community services and social interactions, or the so-called soft skills. Volunteering in the local clinic or hospital or helping in a health fair will teach you that most of patients need more than physical examination and medications. Patients often are looking for a doctor that truly cares about their emotions, listen to their stressful stories, and treat them with respect as if they are their own family members. This often entails long-term relationship and follow ups and investing significant amount of time and energy.

Most of my previous exposure to patient care was in a trauma and emergency setting which often involves helping many patients with no opportunity to build long-term relationship. So, my thought always was that I might not be a good fit for continual care of the same patient cohort, and I should pursue a path in emergency medicine or perhaps surgery. This was my mentality when I came across the PCM Scholar program which its main purpose is to provide you with the opportunity to build a long-term relationship and longitudinal care for the same patients. I convinced myself to join the PCM program because I wanted to gain experience building respect and rapport in an out-patient setting. My hope was for this program to provide me with a different perspective about patient care and now after a year of being a PCM scholar I can see how it changed my perspective and gave me a holistic understanding on the nature of health care. It definitely was one of the best decisions that I made during this first year.

My preceptor was a new recruit of UIC, so he did not have long-term established patients. This actually played out to my advantage as I could start with several patients from the first session and build the long-term rapport and a few of them kept coming back just for me! Even though I did not get to follow any patient more than 2 or 3 times, I still liked that the same patient remembered me and our discussions the next time we met and every time there was more mutual understanding and rapport and trust between us. Among the most precious moment I experienced were examining a middle age man coming to the clinic for the first time after about 20 years and it took me several times of follow up for him to do his labs and eventually telling me the truth about him being a homeless person. There was another middle age man who came to clinic to ask for help for quitting alcohol and seeing his progress every time was an amazing experience. There was an old lady who kept coming back with the same abdominal pain and I learned that she had lost loved ones and wanted to talk about her stories and her late husband. Being able to be a good listener and source of comfort to her was such a rewarding experience.

My preceptor had exceptional medical knowledge and social skills and gave me great opportunities to work with homosexual patients, alcoholics, smokers, and even children—sensitive patient population that I had not previously worked with. Overall, the PCM program left indelible moments for me through which I gained

unique experiences and learned a great deal of clinical and soft skills. PCM program had a considerable influence on my views about patient healthcare and I would love to be part of this program for the rest of my education at UIC.

Ravand Samaeekia
2016-2017 M1 Scholar



My Year in PCM

This year in the PCM Scholars Program, I had a chance to see the daily challenges that patients face when managing their health. I had the privilege of following Ms. L—a patient in her 60's—who is managing multiple chronic conditions under the care of my preceptor. From observing the interactions between my preceptor and Ms. L, I've realized that much of the clinician's role is to help the patient navigate the many obstacles that prevent them from reaching their maximum health potential. By following Ms. L's medical journey, I saw how the different aspects of her life complicated her ability to achieve her health goals.

Ms. L had a history of hypertension, type II diabetes, fibromyalgia, and anxiety. During my very first conversation with this patient, she showed me her journal where she had been keeping track of her daily blood pressures. She told me how much she liked writing and how she used it to keep track of her thoughts—there were many messages of positivity peppered in with the numbers that tracked her health. She told me about her struggle with managing the pain related to her fibromyalgia and how on bad days the pain would be so debilitating that she wouldn't even have the energy to get out of bed. She had been trying to maintain a regular exercise plan so that she could keep diabetes under control in addition to medication and diet. She also had started to notice a tremor in her hand that came on without warning. As she talked, it was clear that these issues were affecting both her physical and mental health, but I could see that she was motivated to make changes to achieve her health goals.

My preceptor intervened on multiple levels so that Ms. L could feel more empowered. She asked Ms. L to continue writing down her blood pressure and her daily blood glucose levels in her journal. By asking her to utilize her journal, we could empower Ms. L in a small way to be more actively involved in her health. In addition, we were also able to get a more accurate picture on how her numbers changed day to day. My preceptor encouraged Ms. L to start anti-anxiety medications because she was concerned that her hand tremor was the result of uncontrolled anxiety that came on randomly. Ms. L was hesitant to take these medications because she worried that it would affect her energy levels more severely than how they already were affected by the fibromyalgia. However over multiple conversations over multiple visits, Ms. L felt comfortable enough to take the medications and we saw her hand tremor resolve and her anxiety symptoms improve drastically. I realized how patience and continuous communication could be so rewarding with respect to patient outcome. My preceptor recommended that Ms. L see a rheumatologist to understand how we could better manage her pain from her fibromyalgia.

Lastly, I saw that encouragement went a long way in keeping up Ms. L's motivation. During one of her visits, she had blood drawn to check her HbA1C levels to see how well her diabetes was under control. The HbA1C number had declined significantly—and the words of encouragement my preceptor provided

at those results heartened Ms. L. Her reactions during that appointment made me see how happy she was when she realized that she could achieve the goals that she set her mind to—and how important it is for physicians to acknowledge these achievements.

Ms. L also had a few obstacles in her way in terms of accessing care. Ms. L didn't drive, and recently she and her husband had moved out of the city to a nearby suburb. She liked the new area: it was closer to the gym and she felt more at ease taking walks around her neighborhood. However, it was much farther from her regular clinic. Oftentimes it was her husband that drove her to and from her appointments—which restricted her ability to come to her appointments only during times when he didn't have to work. Days when her husband couldn't drive her, she took two buses in from the suburbs to get to the clinic. On cold days, it was especially a challenge because the weather worsened her fibromyalgia pain, and this took a serious physical toll on her. I saw that she was much more stressed on days that she had to take public transportation to get to the clinic than when she was driven. There were many missed appointments because of these transportation challenges she faced—which meant that she wasn't receiving her care in a timely manner to better manage her multiple conditions. I saw how her issues with transportation directly connected to her health outcomes. I was able to help Ms. L find a transportation service for patients under Medicare that would drive them to regularly scheduled appointments. As long as Ms. L set the appointment up with the service, they would be able to pick her up and drop her off at the clinic. She wouldn't have to wait in the cold at the bus stop and she wouldn't have to rely on her husband to get to the clinic. Hopefully, using this service will relieve some of the burden Ms. L faces when trying to reach the clinic and hopefully this means that she will be able to keep up with her health goals.

From this year, what I have realized is that there are a lot of moving parts when it comes to providing patient centered medicine. It takes a capable and conscientious physician to identify all these different parts and address them effectively. What I am also realizing is that patient centered medicine takes time. It is a process and a continuous conversation. In order to be able to deliver the best care, one has to build trust and respect. Listening to the patient and hearing the other concerns they are bringing up outside of the chief complaint can help foster this patient-physician bond. When physicians hear and address these issues, their patient's trust in them grows—ultimately leading to better health outcomes.

Jissy Cyriac
2016-2017 M1 Scholar





insights into
patient-centered
medicine

The How and the Why

Why do people choose to go into medicine? As a first year medical student, this question is silently pondered too frequently. While spending endless hours trying to master the basic sciences in which medicine is built upon, we tend to lose sight on why we wanted to become doctors in the first place. So why?

Although I can only speak for myself, I truly believe that the majority of future physicians genuinely want to help improve lives of their patients. One of the most fascinating aspects of medicine is that each medical specialty is able to improve an individual's life in a different and important way. Although physicians improve the lives of individuals in various ways, the fundamental basis in which they do should be similar: by caring more for the individual patient's needs, concerns and preferences than the physicians. Even though patient-centered medicine can be defined many different ways, the previous sentence embodies what it means to me.

I like to break it down even more simply to think about why patient-centered medicine is a good model. Each patient is different in an infinite amount of ways. This may sound obvious, but we often forget that although a disease may progress in a similar fashion, the person in whom the disease manifests in is extraordinarily different. This is an important acknowledgment to make in order to be able to distinguish and act on the needs, concerns, and preferences of the individual.

Sure, it's nice to create definitions, but actually being able to achieve and practice medicine utilizing the patient-centered definition takes practice and experience. The first year of medical school allotted me the opportunity to exercise this basic tenet. In a time where the knowledge of pathology and disease is in its infancy, I chose to focus on advocating and caring for the patient as a unique individual instead of treating them as a case.

For me, patient-centered medicine is how I will fulfill and succeed at why I want to be a doctor.

Drew Ormseth
2016-2017 M1 Scholar



Learning to Care

A lot is said about the difficulties of medical school – overwhelming information, sleep deprivation, academic isolation, etc. Little, if anything, is ever said about the challenges involved with learning to effectively communicate and coordinate a healing relationship with one's patients. Most try to say that this aspect of medicine should come naturally so long as the medical student is competent with normal social interaction, and in many cases that is true. There are countless situations, however, in which it is not. Yes, most people can talk to somebody about how they have been having back pain recently. Very few walk into an exam room ready to respond when the patient, a perfect stranger, admits that they've been struggling with depression since the loss of a father. What do you do when an elderly couple erupts into a loud argument with each other and cannot be silenced? What about when that argument is in your second language?

Through my experience with the PCM program, I have been fortunate enough to have this latter point highlighted through anecdotal examples as well as identified during my clinical experiences. The situations above were my own. With them and others I have seen my own communication fail, not because I went in nervous or unprepared but because there are certain aspects of medicine that are only perceivable in hindsight. It is during times like those that any relatable advice given in plenaries or small groups goes out of mind. You trudge on the best you can, but I cannot help walking away wondering "what just happened."

To me this is the true reason for the PCM program and why I have been fortunate enough to be a part of it. It's not only getting the information from the patient but understanding how and why they came to see you in the first place. The patient with back pain may just have typical back pain from aging or it may be connected to the depression they are experiencing at the loss of a loved one. The elderly couple claimed to be in for a skin lesion but when asked further their hearing, depression, and entire relationship problems exploded.

It was the same with my continuity patient. At first it seemed his diagnosis was a minor worry of his as his outdated contact information made it impossible to contact him and he skipped appointments. When I finally was able to talk with him again, however, it came out that he was avoiding the referrals to specialists because he was afraid of adding continuous appointments to his already stretched schedule. He was already using his vacation days to see his PCP (my preceptor) and could not comfortably ask for further time off work. It wasn't as though he was trying to avoid the treatment plan; it was that he currently couldn't afford to adhere to it.

PCM teaches you to understand these circumstances that patients bring with them, both those apparent and those hidden, in order to heal the true problem rather than just patch its visible manifestations. It's something that most certainly isn't natural in a competent student, but it is something that is worth the effort in trying to develop.

Andrew Bellino
2012-2013 M1 Scholar

The Little Things

It dawned on me that I hadn't called my patient since the first day I met him. He was an elderly patient with a lot of health conditions, including hypothyroidism and a heart condition, and I felt a surge of guilt that I had gotten so busy with my work that I forgot to check up on him as I had promised. I was nervous as I dialed, worrying that he had forgotten me just a few weeks after our meeting. The phone rang until right before the voicemail was going to take over. He picked up and I suddenly felt the confidence envelop me. I asked him how he was and if he had been keeping up with his medications. He sounded so excited to hear from me. Not only excited, but grateful that I had taken some time out to check up on him. He had been experiencing shortness of breath for the past week but did not know why and had not told anyone about it. Because he was elderly with a heart condition, I immediately became concerned and told him I would talk to my preceptor within the day and we would figure out a plan. He sounded so relieved, as was I thinking to myself, if I had not called him when I did, things may have gotten worse and he would not have even seen a doctor.

At that moment, I learned how important patient-centered medicine really is. Not only does it reduce complications, but it also makes the patient feel at ease and relieved knowing that someone actually cares about their health and well-being, especially if they are lonely or don't have a large support system in their lives. We talked on the phone for a while after that, and he told me about his wife and about how he used to be a professional pool player and we talked about politics and international affairs. At the end of the day, he needed someone to talk to, and I was honored that I could be that person for him. Although I may not have a complete medical education to help him in that way, at least I could help him by just simply listening and being there for him and making the appropriate phone calls. I realized that the little things really do count even in medicine, and I am grateful that I am part of a program that taught me this.

Azra Bhimani
2012-2013 M1 Scholar



Working with patients this year has been the best experience I've had in medical school. I've seen how my class work translates into real life, but more importantly I've seen how this impacts people's lives. Through the Patient-centered Medicine (PCM) Scholars Program, I was paired with a physician in Family Medicine and the diversity I've encountered in the patient population has been incredible.

Every patient I see is different, every case is different, and this has been incredibly stimulating because I don't know what to expect from one person to the next. I've seen patients from a 1 month old infant to a 52 year old, some with chronic illness that will require lifelong management like diabetes and others with acute illness like a urinary tract infection. But then again, being a first year medical student with no clinical experience, I didn't know what to expect to begin with.

My mentor has been absolutely amazing with her guidance and feedback. She has exhibited patience when I've been in clinic with her and her feedback has helped me grow not only as a student but has also assured me that I made the right choice in attending medical school. Needless to say, the challenges of being a medical student are daunting, and at times overwhelming. But this program and the experiences with patients and mentors have been encouraging.

For anyone interested in the program, I would say it is important to keep an open mind and an open heart.

Because you will see the human impact of medicine.

Roberto Bonilla
2013-2014 M1 Scholar



For my first year of medical school at UIC, I was grateful to be a part of the Patient-centered Medicine (PCM) Scholars Program. I was only able to meet with my continuity patient initially due to scheduling conflicts that prevented me from being in the clinic. However, I did get a chance to meet a lot of patients coming into the family medicine/ob-gyn clinic during my other monthly clinic visits. I was able to take HPIs and start working on my skills to develop trust and rapport with the patients, and I learned how to communicate with different patient personalities and patients from different economic and cultural backgrounds. I think one of the most critical skills I learned this year was to be respectful and nonjudgmental of patients and encourage them to express their fears and concerns. I admired how my preceptor practiced patient-centered medicine in the clinic when she would always ask her patients if their current treatment plan was working well for them and if there were any problems, such as insurance coverage or lifestyle changes, that made their treatment course or medication access difficult. It is important as a physician practicing patient-centered medicine to be aware of these things and offer guidance and support.

There was one patient, I remember, who could not afford her medications. She had to be hospitalized as her condition worsened. I admired how my preceptor took the time to offer hospital resources to the patient so that she could undergo necessary treatment that her finances would not allow.

The PCM program has helped me to understand more about what challenges patients may face and how physicians individualize patient therapies in order to make them most effective.

Lindsay Boven
2013-2014 M1 Scholar



Lessons Learned from a Pediatrician and Patient Patients

I have been fortunate enough to have many experiences working with patients, yet it never ceases to amaze me that I continue to learn from each and every encounter. This year I worked with a compassionate and dedicated pediatrician. One of the first things I noticed is that he in no way conforms to the “15 minutes per patient” rule. Yes, this means that he is often quite behind and works late into the evening, but it also means that he addresses every patient and parent concern and that he treats the whole patient. He is always warm and makes patients feel as comfortable as possible, whether that means making jokes or funny faces or wearing coordinating cartoon ties and socks, something that is crucial as a pediatrician. I also noticed that he visibly cares for his patients more than any other physician I have ever had the pleasure of working with. He invites patients with no insurance to come to see him, even if it means footing the bill for the practice, he is part of. I will carry the lessons I learned from him with me throughout my career.

Then there were the patients. It is a pediatric practice, so I saw patient after patient come in with the flu, the cold, and requests for vaccinations. It sounds very run of the mill and maybe even a bit monotonous. However, with each HPI and history I completed I began to see that every “run of the mill” cold or flu is unique. They are attached to a person with their own history and their own story. Each child had tried medications that had worked or not worked well in the past, or maybe even needed a different medication because their insurance would not pay for the most typical drug. If I lumped all of these children together, I would not be part of providing the best, individualized care possible.

This is why in an age run by technology, we still have doctors seeing each patient and not some computer or robot treating patients- something that would be very cost effective, but ultimately fatal. It is the nuances that every patient brings to the table that makes medicine continuously interesting and exciting, and I am grateful for that.

Jenny Cueto

2012-2013 M1 Scholar

Click

It was an almost instant transformation after Dr. C walked in. Her eyes opened wide, she sat up straight, and a huge smile crept across her face. The 80 year-old patient, Mrs. J, was the definition of joy. This was followed by an emotional hug as they were reunited for the first time since a check-up 6 months ago.

This was no random occurrence; Dr. C had this effect on almost every one of her patients. They loved her, respected her, and considered her a true friend. Families would greet Dr. C with the same enthusiasm, knowing she would happily answer any questions and engage in a meaningful conversation. This simple interaction amazed me every single time. Everything that the patient-physician relationship should be was being displayed in this seven room geriatric clinic.

My greatest takeaway from the M1 PCM experience was something I would never find in a textbook, workshop, or lecture. Sure, we are taught the importance of empathy, consideration, and respect. We are even presented with statistics on the power of proper patient care. This experience with Dr. C overpowered all of that. Now I really understand. Just being in that room made it all click.

Daven Patel

2014-2015 M1 Scholar



Through the academic bustle of the M1 year, it came as a welcome relief to participate in the Patient-centered Medicine (PCM) Scholars program, where I could practice applying my knowledge of anatomy and physiology to real clinical scenarios as well as work with and observe my preceptor interacting with patients. Before beginning medical school and the PCM program, I thought that interviewing patients and obtaining an accurate medical record would be relatively easy, while diagnosing and treating patients would prove more challenging. However, through my experience with PCM, I have come to realize that for the most part, this is not the case. I now have a better understanding that the patient physician interaction is a learned process, requiring practice, patience, and skill. I discovered that talking and interacting with patients from different backgrounds is an invaluable experience that cannot be replaced by textbooks. The PCM program not only provided me with opportunities to practice these important skills, but also gave me guidance on how best to navigate the nuances of patient physician interactions while simultaneously providing patients with quality healthcare that meets their needs.

One of the more interesting and rewarding experiences I had through PCM was observing my preceptor conduct a patient interview in Spanish. With no Spanish language ability of my own, it gave me a great opportunity to observe how body language and the capability of a physician to talk to a patient in the patient's native tongue can have an effect on the patient's perspective of the physician. My preceptor did not rush the interview but took time to ask the patient about his family and how the patient's health problems affected his quality of life. At the conclusion of the appointment, my preceptor helped the patient put on his coat, making sure that both the patient's daughter, who was in attendance, and the patient understood and felt comfortable with the treatment plan. Through this unique experience, I realized that despite language barriers, the patient appreciated my preceptor's willingness to interact with him in Spanish. Additionally, I found that little gestures, such as helping patients put on their coats and shoes after an appointment further shows an additional level of care that a physician has towards the entire well-being of their patients.

In conclusion, I applied to be part of the PCM Scholars Program because I wanted to gain clinical experience as well as interact and work with physicians and patients in urban and medically underserved clinics. As my M1 year comes to an end, I can say that the PCM Scholars Program fulfilled my expectations and allowed me to form relationships and engage with individuals from different socioeconomic statuses, educational, and ethnic backgrounds. It proved to be an invaluable experience that I feel privileged to have been able to take part in and am grateful for the preceptors and patients who allowed me to learn from them.

Polly Godfrey

2013-2014 M1 Scholar

Never Assume Anything -- You're Probably Wrong

Mr. S was an older gentleman with diabetes that came into the clinic. After speaking with him during his visit he agreed to participate in the PCM program. I received his number and told him I would meet him for his appointment with the pharmacist to discuss some of his medication and testing equipment. Later I was unable to contact him, only being able to leave voicemails on his phone. The day of his appointment, he did not show up. We could not get a hold of him again. I was discouraged because I believed he was unwilling to talk to me, and I also thought he ignored his appointment because he was not interested in being educated about managing his diabetes.

In my next visit with my mentor, she reassured me by saying Mr. S was a really nice man. She was sure he would be happy to talk with me and that I should keep trying, especially because of the health problems that he had. With her help I was able to find an old number for Mr. S and finally was able to get a hold of him.

Hearing the story from his end caught me completely by surprise. His cell phone had stopped working and that is why I had not been able to reach him. Because he had no money for bus fare, he had tried to call to cancel his appointment but the number he had for the doctor's office didn't work. Due to not being able to get in contact with the doctor for a while, some of his prescriptions had run out and he had been unable to get refills on some of his required medicine.

All at once I was thankful for my mentor's encouragement to keep trying and I realized the need for a patient-centered focus in medicine; one where we try to see health care from the patient's point of view instead of the provider's. I saw how my own preconceptions nearly prevented me from helping someone that was obviously in need. People like Mr. S fall through the cracks of our health care system every day. We need to be the physicians that will care enough to make sure they don't.

Bo Marcus Gustafsson
2012-2013 M1 Scholar

My First Year

My experience in the Patient-centered Medicine (PCM) Scholars Program this year has been amazing. I learned a lot about patient interaction, how to talk to patients, and how to take complete histories. When I first started the PCM Scholars Program, I didn't know what questions to ask or the best way to talk to patients. Through practice and the help of my mentor, I quickly learned how to ask the right questions and the best way to talk to patients.

I was assigned to two continuity patients on the first day I met with my preceptor. It was a great experience for me to follow the two patients for the whole year. I built great relations with my patients and I was able to call them every two weeks to check on their health and see if they needed any help from me. My continuity patients were so grateful to participate in the PCM Scholars Program, and they said they would like to continue with this program as long as possible.

In the PCM Scholars Program, I got the chance to participate and experience what we have learned in the classroom. It is one thing to read something in a book or hear it in a lecture and to experience it first-hand. I am grateful to the PCM Scholars Program for giving me the opportunity to experience the patient-centered approach to medicine.

Abdisamad Ibrahim
2013-2014 M1 Scholar



Patient-centered Time Management

Being part of the Patient-centered Medicine (PCM) Scholars Program, I have noticed that a significant challenge to patient-centered medicine is the limited amount of time a physician gets to spend with his or her patients. In order to both write up patient notes and devote a meaningful amount of time to patients, it was necessary to sacrifice time with patients scheduled for later appointments. The result was a painfully evident skewing of the ability to be “patient-centered” for each patient. While I have only a developing background in the management of healthcare, I suspect there are many factors contributing to this predicament—the disproportionate physician to patient ratio, the length of the clinic’s work day, the number of patients per physician hour, and the actual physician’s training to balance such volumes, to name just a few things that come to mind.

With the core values of patient-centered medicine in mind, this type of limitation certainly appears to impact the quality of patient care. Although my preceptor was a very competent and well-liked physician, I could certainly see both him and his patients being much happier and more comfortable with a more compliant schedule. To achieve this, however, is perhaps a much more complicated matter. A solution for such a multifaceted problem almost definitely involves multiple components of the clinic—from the number of physicians and the length of clinic hours to the actual training of the physicians. As medical students, we can best address the latter component. Specifically, we must augment our ability to manage time within the stressed, complication-ridden, time-restrained clinical setting. To improve our ability to personalize care for each patient, we must be able to manage our stress and thoughts in the real-clinical world.

While this is one small step of the many necessary to escalate patient-centered care, the ability to remain calm and sincere will certainly not go unnoticed by patients who need their physicians’ time. There are many problems preventing optimal patient-centered medicine but combining improved preparedness of future physicians with other measures to ensure patients get enough time with their physicians is absolutely necessary.

Jason Huang

2013-2014 M1 Scholar

Opposites

My PCM experience was defined by opposites. I spent the majority of the year with a mentor that did not regularly exhibit patient-centered medicine (PCM) and then had a final session with a very Patient-centered mentor.

Mentor A

1. A 25-year-old female came to the office to discuss a healthy way to lose weight and a recent development of an eating disorder. Mentor A noticed elevated blood pressure from the intake screening and told the patient we had to start her on meds for blood pressure and that we do not have time to discuss nutrition.
2. On my visits, I was told to go in and interview the patients, get an HPI, and present it to the mentor. On several occasions the patient would mention another concern that they had not previously told the intake nurse. When I presented to Mentor A, she said we were only addressing what the patient had told the nurse. Upon re-entering the patient room, Mentor A started again by interviewing the patient and taking a full HPI.

Mentor B

1. A 63-year-old female came to the office presenting with chest pain and an elevated heartbeat. She was very tearful and mentioned multiple times being scared of something seriously being wrong with her heart. After an EKG ruled out any emergent abnormalities, Mentor B further discussed with the patient her feelings of being scared. In the extra 5 minutes Mentor B spent with the patient, she shared that she's been depressed for quite a while, does not have any support system because she doesn't want to burden her kids, and was grateful the doctor took time to ask and provide a referral to a counseling service.
2. During my visit, I was told to go in and interview the patients, get an HPI, and present it to the mentor. As I was presenting to Mentor B, she would ask me questions about possible follow-ups, items I may have missed, and possible treatment plans. Before returning to the room we, together, made a list of additional questions to ask and a general treatment. Mentor B then let me discuss these with the patient and jumped in only if there was a question I could not answer.

When I started PCM, I thought I understood how the PCM principles appear in practice. What I didn't expect to learn so much about is how medicine (and teaching) is practiced in the absence of PCM. It is unfortunate that so many providers do not consistently practice under the pillars of PCM and I feel very fortunate to have had this exposure early in my training so that I may emphasize this approach throughout my training and into my practice. I am also inspired by a possible career in primary care and education that is fundamentally based on PCM.

Lauren Hughes
2012-2013 M1 Scholar

Cystic Fibrosis

In biochemistry, cystic fibrosis is a CFTR mutation.
In physiology, cystic fibrosis causes obstructive lung disease.
In genetics, it passes as autosomal recessive over many a generation.
But in clinic, cystic fibrosis is a toddler that coughs and wheezes.

Today his siblings came to clinic all with fevers and colds.
And meanwhile, their brother with CF is hospitalized for an infection.
All have hope that little Johnny will be better as the week unfolds.
As their mom's birthday is Saturday and there will be a celebration.

Johnny is a courageous and resilient boy in his quiet glory.
He is more than his condition.
Behind the cystic fibrosis, there is a life, a person, and a story.
PCM allows this story to be seen by the physician.

PCM transcends the science.
And between patients, family, friends and physician, comes a great alliance.

Danielle Nagel

2013-2014 M1 Scholar



Phone calls. I spent an entire IPC visit on the phone. That is 4 hours of phone calls. You would imagine that a problem which required 4 hours of phone can be extremely complicated. But it wasn't.

A patient came into the clinic that morning with a handful of referral papers from a sleep clinic. This patient was diagnosed with sleep apnea, after noticing an elevated blood pressure, and needed to visit an oral specialist to get a mandibular advancement device (MAD) made for him. The patient left the sleep clinic with about 10 pages of instructions, seven different phone numbers, and the acronym MAD. That patient didn't know who to call or what MAD even stood for; and so, began my morning of phone calls.

After 4 hours, I was able to set up an appointment for this patient and educate him on exactly what an MAD was going to do for his sleep apnea. When I finished talking to the patient, he said "Did you know I'm an internal med doc at Cook County and I had no idea how to navigate this problem, let alone understand what a MAD was."

This patient is only the exception because he himself was a doctor, but the situation he was in is one that is too common in our health care system. It elicits the importance of patient-centered medicine. Not every patient has a medical student that will spend 4 hours on the phone trying to navigate their care, yet I'm sure every family medicine doctor has a few patients that need that.

PCM gave me the opportunity to help tailor the care of some patients, and also highlighted the type of attention each patient needs to be successful at managing their own care.

Yahaira Plata
2012-2013 M1 Scholar



Before beginning medical school, I knew that I would have to build a good rapport with patients in order to be an efficient doctor. Throughout our first year, we learned what it takes to create a comfortable atmosphere for the patient and had several opportunities to practice in a controlled setting. However, it was not until my visits with my PCM preceptor that I really saw the advantages that creating good relationships with patients could bring. It was in my observations and interactions at the UIC Family Medicine clinic that showed me the importance of building good rapport with patients.

My preceptor is a Family Medicine physician, so the cases I observed were diverse, ranging from spider bites to child wellness visits. During those visits, I learned a lot of new medical terminology and treatment protocols. Most important, however, were the social interactions that were involved, because it was in those interactions that my preceptor and I were truly able to help the patients. One such case involved a pregnant woman, who was already one week past her due date, but was there for a normal checkup. Upon examination, the fetal heart rate was normal, and the mother was in good health. However, she seemed distressed. I told her that I noticed she seemed anxious and I asked her what was wrong. Although she was shy, she suddenly opened up to me. She told me that besides the annoyance of not having delivered yet, most of her family was back home in China and they were pressuring her with news about whether the child was born yet. On top of that, one of her family members is a physician there and told her that she should be concerned that she had not delivered yet. For that reason, she was stressed and did not know what to do. I talked this issue over with my preceptor, at which point, she explained to the patient that everything was fine and unless she had a good reason to induce her before 42 weeks' gestation, she just wanted to let events proceed naturally. However, my preceptor saw for herself the patient's stress and made a plan. She was convinced that the patient would go into labor within the next 4 days, but if that did not happen, she promised to induce the delivery. She also offered up a natural resolution of sipping castor oil, which would hasten the delivery as well. The patient felt reassured and agreed to the plan. Without having asked her a simple question, the patient would have left that visit feeling as worried as before she came in. It is important that we notice and listen to patients' concerns, because often they will present with issues beyond just their physical complaints.

A diverse bunch of patients present to the clinic every day with different issues, and no matter what the concern, we will need to recognize all the possible factors that could be involved. The patient may want to be adherent but cannot afford the treatment, or he or she might be depressed because of things going on at home that has nothing to do with what their presenting to the clinic with. We, as physicians, need to create a comfortable, trusting environment for patients to talk to us about anything. By observing my preceptor, I saw how patients spoke candidly about their concerns and how she was then able to address them.

The Patient-centered Medicine Scholars Program has taught me that medicine is not just about applying the basic sciences, but also building trust and seeing the patient holistically, empathizing with their situation, and addressing their concerns in a comfortable environment.

Alexandra Roybal
2012-2013 M1 Scholar



Finding Balance

William Osler once noted that “the good physician treats the disease; the great physician treats the patient who has the disease.” It may be reasonably inferred from this statement that merely mending, patching, or preventing various ailments and diseases does not encompass the ultimate goal of the profession of medicine. Instead, the ideal physician is the liaison to the treatment of the entire patient: mind, body, spirit, and aliment included. This is only attainable by respecting and fully understanding not only their patient’s disease, but their condition as a whole. Never has this quote been more pervasive than in its relation to foundations of patient-centered medicine.

Although I have learned much about the science of medicine during this first year of medical school, I am always drawn back to the core values that the Patient-centered Medicine (PCM) Scholars program has instilled in me. Admittedly, coming into medical school I understood little about what it meant to practice patient-centered medicine other than the cliché ‘everyone is different and come from different walks of life’. However, after just this one year, I feel I am starting to understand the true meaning and strength of what having a patient-centered approach in our practice is and can do.

To become the best physician for our patients, we must be adequately skilled in our technical abilities, but most importantly, we must have a genuine knowledge and understanding of the human condition. It is only through this careful balance of both the art and science of medicine that we may ultimately bring comfort and relief to a patient.

Daniel Wang
2013-2014 M1 Scholar

The Whole Picture

You never truly understand how important Patient-Centered Medicine is until you actually experience it. It seems like a pretty straightforward idea—something that every physician should be practicing in his or her clinic. A patient should be involved with the decisions made in their care and be comfortable with their treatment plan.

My PCM patient was no exception. After coming into the clinic with high blood pressure and already being on two hypertensive medications, he was placed on a third by another physician that he did not feel necessary. He tried to be compliant with the doctor's orders, but the extra medication just made him feel terrible and so eventually he stopped taking it. In theory, the plan should have worked; it should have controlled his blood pressure and he should have felt fine. Instead, he felt nauseous and light-headed and he still had the problem. Coming back to the clinic, he was placed on another different medication that he was willing to try.

Sometimes we as physicians get frustrated at the fact that patients are not being proactive in their own care. Uncontrolled diabetes, patients that continue to smoke even after being diagnosed with lung problems—these are common issues that physicians see on a daily basis.

The most important aspect I learned from PCM was to find the root cause as to why. How come, despite not feeling well, they are not taking their medications? In order to help our patients, we have to understand them as a whole. It is not just one system or one issue that defines them, so why should we treat them that way?

Eesha Bhalla

2014-2015 M1 Scholar



Reflection on My PCM Experience

Through learning within Family Medicine, I learned more about the physician's role in improving the health of patients. Many of the patients I worked with came in as walk-ins with many health concerns, too many to be addressed in one visit. Many did not have continuity of care with one physician and, if they did, often did not make appointments regularly to adequately and consistently address their health concerns. This made me realize the importance of establishing strong relationships with patients, so that patients have a physician that they trust and can get to know, and to have an advocate to help them navigate the health system. Without this, I believe many patients do not get the treatment they need. Also, with a continuous doctor-patient relationship, the physician can pull the patient sustainably into the health system, by holding the patient accountable for regular visits and discussing a common treatment plan to follow through time. Many illnesses I saw in family medicine were chronic, and needed to be monitored through time, so I think it is also important that the physician is able to motivate the patient to prioritize their own health.

Family Medicine has a crucial role in these elements of health, because it is often the first place that the patient is seen by the health system. I do not think that long wait times and fifteen minutes visits are ideal for achieving these goals, so I learned it is also important to connect patients with other health resources in the community. For me, I am still learning how to navigate the health system and about my continually evolving role within health care.

To continue learning and improving my patient-centered care, I believe it is crucial that I self-reflect on how I am serving and how I can better connect patients to the health system within their context, including their community resources. Regardless of the residency program pursued, I believe that patient-centered medicine should be the foundation for which one treats patients and that physicians should continually strive to keep patients connected to the healthcare system through teamwork with the patient and across the many health fields.

Amalia Hatcher
2014-2015 M1 Scholar

Is there anything else?

There was nothing more anxiety-inducing than my first patient interview. As I struggled to remember OLD CARTS and the ever-so-intimidating Social History, I silently prayed that in my nervousness, I would not blurt something that would inadvertently break my oath to do no harm. Noticing my apprehension, my preceptor taught me one of the most valuable questions I should ask during an interview – “is there anything else”? As I learned through PCM, very rarely do patients come into the clinic willing to discuss every facet of their health, especially issues they consider sensitive or embarrassing. Asking “is there anything else” lets patients know that they are in a safe, caring environment, and that we as doctors want to help in any way we can.

I first realized the importance of this question during my second visit with my preceptor. A patient had come into the clinic for a wellness checkup, and her only complaint was chronic low back pain. I had noticed the patient looked hassled and heard the strain in her voice, but as she did not mention stress in the interview, I chose not to report it back to my preceptor. As my preceptor began to ask the patient “is there anything else?” she slowly began to open up, and eventually broke down crying. The primary reason why she came into the clinic was because she was feeling depressed and would like an appointment with a counselor.

“Is there anything else?” is now a question I ask my continuity patient with every call, email, and face-to-face encounter. At first, he would ask me questions like how to cancel an appointment or prepare for a colonoscopy. Over time, however, he began to come to me with more personal concerns, such as his glucose levels affecting his life insurance premium or his struggles with picking up his smoking cessation medication. At the beginning of the year, I thought my lack of medical training rendered me completely useless in the clinic. Now I see that taking a good patient history is one of the most valuable contributions I can make.

Eden Liu

2014-2015 M1 Scholar



Importance of Patient–centered Medicine for Patients with Diabetes

From the blur of the first year of medical school, I can remember fragments of biochemical pathways, renal physiology, and maybe of the structures in the heart. Frantically memorizing the Krebs cycle, neurotransmitter names, and anatomy mnemonics characterized most of the first few months, seeming only to leave transient knowledge in my brain. Clinic visits with my PCM preceptor, however, left a more permanent mark.

During my first visit at the family medicine clinic, I was immediately immersed in a world that starkly contrasted with the image of medicine I had developed in the classroom. In biochemistry lectures, I attempted to develop an understanding of the molecular basis of diabetes and worked diligently to memorize the different drugs that targeted the malfunctioning pathways. At the clinic, however, my preceptor emphasized the importance of nutrition with diabetes. In fact, he was often reluctant to prescribe medication to his patients who were first diagnosed with diabetes, preferring to sit with them and describe effective diet changes to reverse the disease. None of his nutritional interventions were discussed in the classroom, but he has astounding success. The key is his patient-centered approach to medicine. Rather than simply looking at the lab results and immediately writing a prescription for his patient, he sits with his patients and asks them how their lifestyle has allowed their health to deteriorate into diabetes. Nonjudgmentally posing questions and showing genuine concern for their health, he eventually gains their trust. This relationship facilitates frank discussion regarding the major nutritional changes that must occur for their diabetes to end. And it works.

At each of the few clinic visits that I completed each year, I encountered at least one diabetic patient who has achieved significant improvement by following my preceptor's nutritional guidelines. Some patients who had severe diabetes improved their condition so drastically that they were able to stop taking medication. Others completely reversed their condition so that they no longer had diabetic A1c levels. These amazing results were largely accomplished by adhering to the principles of patient-centered medicine. I am excited to continue becoming immersed in the PCM program and UIC and learn from the extraordinary faculty who lead as examples of the importance of patient-centered medicine.

Elizabeth Nagel
2014-2015 M1 Scholar

Companionship

It's hard to imagine the first year of medical school is almost over. Having wanted to be a physician for as long back as I can remember, my definition of what medicine epitomizes has changed several times. However, throughout this year I've realized most of my expectations of medicine have been naively idealistic, and through all of the realities one definition has stuck: Companionship. To me, the heart of patient-centered medicine is companionship. Learning to form a relationship with a patient and follow their care as a member of their healthcare team has been invaluable in understanding the importance of being able to adapt to the patient's needs to optimize their care.

It was only after building a relationship with my continuity patient, Ms. L, that I truly understood the meaning and importance of this companionship in the bond between the patient and the health care provider.

As I interviewed Ms. L and took her history during our first meeting before she spoke with the physician, we delved into her work and social life. She told me about her family with a glint of tears in her eyes. "Even though I'm surrounded by my family – I have four kids who all live close by—there are so many moments that I just feel so alone. I never know what to do, but usually all I can do is hope for it to pass..." Ms. L had been suffering depression since her mother had passed several years ago. She had never seen a therapist and continued to suffer through her condition for years, without finding the "courage" to talk to her loved ones about it.

As she told me her story, opening up to me regarding some of the things that made her feel most vulnerable, I felt so honored. She had chosen to trust me, when she could not even bring herself to talk to her loved ones about her health. On our very first meeting, she was willing to provide open and honest answers to every question I asked of her. Why? Simply because I was a future physician. I realized the sacred privilege and bond caregivers are entrusted with as patients share some of the most intimate and personal details of their lives in seeking better health. This is what companionship meant. Being able to be an unbiased, non-judgmental crutch for an individual, and working as a physician-patient team to achieve optimal health.

At the end of her appointment, Ms. L was given a referral to see a therapist who would be able to better help her with her depression. We exchanged phone numbers as she consented to allow me the privilege of following her care. In the months that followed, we maintained a relationship via phone, as I talked to her about how she was feeling and kept track of her healthcare and treatment plans. Unfortunately, due to her busy work schedule, she was unable to make an appointment to see a therapist or return to see the physician for a follow-up visit. This is the reality of the modern life that far too many—including myself—face, in which we compromise our health needs as we get lost in the fast-paced demanding natures of our daily lives. Yet, she mentioned that knowing I would be calling her and was invested in her healthcare motivated her to actively adhere to her treatment plan. Hearing this was so inspirational, in knowing

the profound difference a few minutes on my behalf every week could make in another individual's life.

In my belief, this companionship built off of the trust that another person cares about the health and life of a patient should be present in every physician-patient interaction. It is what we ideally strive towards, but far too often fall short of because of ever present challenges and barriers. Yet, this awareness is what is most meaningful and instrumental in transforming a plan of treatment for a patient into a goal of healing.

I will be forever grateful to Ms. L for teaching me the importance of this partnership and companionship and inspiring me to strive to form this bond with every patient I interact with.

Ashley Patel

2014-2015 M1 Scholar



More than Just Medicine

As physicians, we dedicate our lives, with humility, to the service of humanity—that is, in order to fulfill our foremost purpose of helping patients, we must continually remember that as physicians we do not treat a consortium of diseases but rather, we treat people. This, I believe, is an important distinction to make apparent. Often occupied in learning the basic sciences, clinical skills and procedural training, it is easy for the medical student to lose sight of this.

Through the PCM Scholars program this past year, I had the pleasure of gaining exposure to the clinical world of medicine, a much-welcomed discontinuity from the endless hours of studying and my first such foray in my medical career. Despite the medical wisdom both my preceptor and his colleagues have bestowed upon me, what I learned most stemmed not from them but even more so from the patients with whom I was fortunate to meet. With each subsequent patient I interviewed, I cultivated an understanding that, as an upcoming physician, I need to be adaptable to the concerns of each individual patient. Not only should I consider the medical implications of the patients' visits, but also the impacts on their social relationships, work, and overall well-being.

My training in Patient-Centered Medicine will certainly continue, and as I reflect on my experiences the past several months, I look back with pride in what I have learned and look forward to my continued development.

Samuel Muench
2012-2013 M1 Scholar



Critical Language

Simple words can have great influence. One of the calls I made to a prospective PCM patient happened just before the Thanksgiving holiday, which, as a first year medical student, was a critical time to have a day to spend with family, and, as an out of state student, it also meant a flight, days of travel, family reunion, and lots of excitement on my part. It was also the first time to leave the city of Chicago and travel to warmer weather for a few days. Ticket prices were high, and my only chance to visit was during the weekdays. I looked at the classes' schedules, made sure I would attend all mandatory classes, and purchased my ticket with a huge smile on my face!

After all my preparation, I called the PCM patient hoping to finally reach her: I had left messages and we had been planning to meet for over a month with no luck. And it happened! I was able to reach her during her break from work, and we made an appointment for the week before thanksgiving. I was all set; everything had worked out and I was one happy medical student. However, when I arrived for our appointment, the patient was not there. I did not give it much thought and hoped we could meet at another time.

I went on the short holiday, charged my batteries, saw my family, and enjoyed the time very much. I also knew I would not see them again until the next thanksgiving holiday making the time with them even more special. I called the patient upon my return, scheduled another appointment. When we met, I was delighted, hoping to be an added benefit for her, an extra hand, accompany her to all appointments I could attend if she wished, and was very excited. She shared her personal background, I listened attentively, and I felt the meeting went very well.

After the meeting, the preceptor came in, we all discussed the next meeting, the patient left, and I stayed to discuss what I had seen as a very beneficial visit with my preceptors. "The patient liked you and would be willing to see you again. But she missed the first appointment because she did not like that you went on vacation rather than seeing her." I did not make any attempt to clarify the difference in dates that in fact there was no conflict, and I had made the appointment before to ensure I saw the patient. Because, it did not matter, the patient felt this way and I had caused the feeling. My preceptor was very helpful and honest in her feedback, and I will not use the word holiday or vacation when scheduling an appointment, because it is not about my agenda, but rather, patient has to feel they are the priority. We must ensure patients feel heard, important, and comfortable. This is critical language.

Camila Castellanos
2015-2016 M1 Scholar

The Absent Patient

I stood next to my preceptor as he discussed nutrition with a diabetic patient, wearing my freshly pressed white coat that had already become slightly too small due to lack of exercise and excessive take-out meals. The patient, Mrs. S., had made dramatic changes to her diet since her first visit, and as a result lost 12 pounds within two weeks. My preceptor was confident that if she kept it up, we would be able to help her get her hemoglobin A1c levels back to normal without the use of medications. I was excited to be involved in her diabetes management care, eagerly following her to the front desk so that I could make sure that I would also be in the clinic when she came in for her next appointment. In between appointments, I followed up with her via text, checking in to see how she was keeping up with the diet plan we discussed.

Mrs. S. was the last appointment scheduled for the day. All afternoon as we were seeing other patients, I wondered how much progress she had made in the last few weeks. My preceptor and I were both eager to see the numbers. However, 4:45pm came and went, and she still had not checked in. Shortly after 5pm, my preceptor was packing up his bag and the clinic was getting ready to close. Mrs. S. had missed her appointment.

Mrs. S. had missed her appointment because she was unable to leave work early that afternoon. I continued to follow up with her and encouraged her to schedule another appointment with my preceptor as soon as her schedule would allow. She never got around to scheduling another appointment, but she did text me saying that she went to another doctor and her sugar levels were high, so the doctor put her on Metformin. She was hesitant about scheduling another appointment with my preceptor because she couldn't afford to pay a second co-payment.

Mrs. S. demonstrated tremendous progress towards managing her diabetes through diet, but we did not have a chance to follow up in person and continue working with her after that. Given my preceptor's successful track record of getting his patients' diabetes under control without the use of medication, it was disappointing to hear that she had to be placed on Metformin. We aimed to provide the best, patient-centered care possible. Unfortunately, we were missing the patient. In our careers, there will always be absent patients like Mrs. S. In treating our patients, we cannot forget the social determinants that also contribute to health.

Jennifer Chang

2015-2016 M1 Scholar

There is one specific encounter with a patient that I remember very clearly and really inspired me. A 40 year old man came in with severe shortness of breath. My preceptor prescribed him some steroids and asked him to come back in two weeks for a follow up. When he came back, the shortness of breath had gotten worse. I could see in his eyes that he was really scared but did not want to admit that to the doctor. His career involved a lot of manual labor and since the onset of the shortness of breath, he was unable to do his job, and this was really upsetting him. It was all he could do not to cry. As soon as my preceptor entered the room, she could sense that he was worried about what was going on and the way she handled the situation was fantastic. Instead of taking notes or sitting at the computer, she gave him her whole attention and reassured him that she was going to do her best to help him. She spent almost 45 minutes with him talking through all his options and explaining each of the tests she was ordering. By the end of the visit, he was more relaxed and confident that he would soon be feeling better.

This moment really stuck with me because too often we hear about bad experiences with doctors. Either they are too distant from their patient or they don't spend enough time with the patient. It was really great to see my preceptor take the extra time to make sure her patient was getting the care he needed. It was inspiring to see a physician who did not care about getting a little bit behind for the rest of the day in order to spend as much time as was necessary with the patient. I hope that more doctors will follow her lead and start to make the patient their first priority.

Surbhi Jain
2015-2016 M1 Scholar



The “Simple” Practice of Primary Care

Coming into medical school, I thought I had a good idea of how doctors interacted with their patients. Through my personal experience as well as the opportunities I had to shadow physicians, I formed an image of interactions between patients and primary care doctors as relatively simple. This notion was completely changed throughout my first year of medical school as I met patients of diverse backgrounds and learned that not only their medical concern, but also their culture, economic and social status plays an important role in their overall health care.

One of the wonderful characteristics of University of Illinois-College of Medicine is the diverse patient population students are able to work with beginning in their first year. I remember reading about the patient centered medicine program and thinking that this would be a great way to get involved with patients as a first year medical student and an excellent way to form relationships with patients, specifically those from underserved populations. I initially hoped that through the patient centered medicine program, I would be able to gain more exposure to patients and have the opportunity to build a relationship with a continuity patient. Throughout the year, I progressed in my ability to speak with patients and obtain their history; I also gained a better appreciation and understanding of the role of primary care providers and the importance of treating the patient as an entire person, not just as their illness.

This newfound understanding began on my first visit to the clinic where I met with my preceptor and later met with the continuity patient who I would be following throughout the year. This patient had a history of diabetes and was very open to speaking with me during the visit. I was nervous and excited to start working with the patient and to help her in any way I could. A few days after the visit, I began emailing with the patient and helped her to locate some housing resources, as she was interested in finding a new place to live. As I sifted through the various resources, I realized that I never considered housing to be a part of healthcare; however, housing was a specific concern for this patient and could impact her health, such as creating increased stress. I remember talking with the patient about a meeting she had scheduled with a housing resource and she expressed her frustration since she traveled to the meeting, via public transportation, only to find that there was actually no meeting that day. While I am not sure the circumstances behind the meeting, I found that an underlying theme many underserved patients face is the ability to travel places they need to go, such as for work or doctor's appointments. For many, it is easy to get in the car and drive to the doctor's office; however, for many underserved patients it can be a long commute to be able to receive basic healthcare.

Throughout the year, I tried my best to coordinate my schedule with that of my patients in order to attend as many of her appointments as possible. This proved difficult at times as the patient often missed or had to re-schedule her appointments due to work or other conflicts. As a physician, it can be frustrating

when a patient misses appointments, especially when a patient is managing a chronic condition; however, I think this situation also reflects that work or other life events may take priority over someone's healthcare. While others may be able to take a day off of work, for some this is not an option due to their economic situation.

During the second half of the year, I was able to attend various appointments with the continuity patient I was following, and it was really rewarding that the patient wanted me to attend appointments with her and felt that she could discuss her medical concerns with me. Throughout the year, I gained an appreciation for the challenges underserved patients face that may impede their ability to comply with their treatment. When family, housing or job factors arise in one's life, it can be difficult to make one's own health a priority.

Working with the continuity patient was a wonderful experience and I hope to carry what I learned into my future. A patient is so much more than their chief complaint. Their complex social, economic and cultural backgrounds make each patient a unique individual requiring a treatment plan that fits with their life. I personally believe the role of primary care physicians is underappreciated as they deal with complex medical complaints in an even more complex context. Additionally, they form long-term relationships with their patients and serve as a safe and trusting resource for their patient. I hope to use this new appreciation and understanding of patients to practice medicine in a patient centered manner, knowing each patient brings their life history as a part of their health history, making the best treatment anything but simple.

Mallory Hawksworth
2016-2017 M1 Scholar



The Most Invaluable Experience

Participating in the PCM program has provided me with a wonderful opportunity to learn from and work with a great patient-centered preceptor and continuity patient, both of whom have taught me a great deal. This experience has allowed me to learn more about and better appreciate the humanistic aspect of medicine and the patient's perspective. The various aspects of the program, such as following my continuity patient, working with a patient-centered physician, and attending the Lunch and Learn lecture series, have also taught me to appreciate some of the factors that may play a role in the patient's health.

At first, I remember having a difficult time contacting my continuity patient and trying to develop a relationship with her. As I accompanied her on her visits to the Outpatient Care Center and talked with her throughout the year, we developed a better relationship. Spending time with her helped me to not only understand more about her various medical issues, but it also helped me learn more about her as a person. I began to appreciate how the various issues and factors in her life affected her health, especially the recent passing of her late husband. With time and various changes in her life, especially having two young girls move in with her, I was able to observe the patient change from being fairly indifferent about her health during our first encounter to wanting to take better care of herself by our last encounter. As I got to know her better, the patient also felt more comfortable with me such that when I asked her if there was anything, I could do to help her, she told me about various issues she was having and asked if there were any extra resources or help available for her. Being able to investigate the different resources available to the patient using the resources I obtained through the PCM program was very rewarding and allowed me to serve as an advocate for the patient. Having the experience of contributing to the patient's health by trying to address the underlying factors that affected both her health and/or her access to healthcare was valuable and something I hope to continue to understand and do in the future.

Having the opportunity to observe, work with, and receive feedback from a physician who practiced patient-centered medicine was another valuable learning experience. I was always inspired by and in awe of my preceptor and his relationship with his patients and his focus on patient-centered care. At the beginning of a patient encounter, my preceptor would learn how the patient was doing, not just with regards to medical issues, but also in terms of life changes since the last visit. After catching up with the patient, he would then explore the medical issues that brought them in, all while maintaining a patient-centered focus. For instance, he would explore how the issue has been affecting the patient's life, understand how the patient would like to proceed and the patient's opinions, and address any questions or concerns the patient may have had. My preceptor was very considerate of his patients and tried to help the patients feel comfortable during what could be considered an uncomfortable time for most of them. Observing his compassion for his patients and his practice of patient-

centered medicine has inspired me to focus on getting to know each patient better, exploring factors that may affect their healthcare, learning how I can be of assistance to them, and understanding their unique perspectives and opinions. I also appreciated the Lunch and Learn lectures since they were very informative. Having the opportunity to learn more about various factors that may affect a patient's health and access to care from patient-centered physicians was eye-opening. Also, hearing everyone's opinions and experiences was also great since it helped us apply the concepts we were learning about. Attending these lectures helped me gain further insight into the healthcare system and the importance of understanding the patient's experience while also inspiring me to continue working toward practicing patient-centered care.

Observing and having the opportunity to work with a continuity patient and a patient-centered physician helped me to understand how to build rapport with patients and the importance of having a strong relationship with the patient. Through my experiences in the PCM program, I have come to further appreciate the patient's perspective and various factors that can affect a patient's health and access to healthcare. Moreover, following my continuity patient to her medical visits allowed me to gain insight into her experiences with the healthcare system as well as her feelings and thoughts about her interactions with healthcare professionals. Overall, the program has not only helped me develop my clinical skills, but it has also helped me learn how to be more patient-focused and how to better advocate for patients and assist them as a medical student and future physician.

Anjella Manoharan
2016-2017 M1 Scholar



I Like Her

I spent a year before starting medical school as a health educator in Chicago. I worked in a high school clinic and spent a lot of time speaking with students about nutrition, sexual health, birth control options, and a lot of time just talking about their life. I was referred patients from the nurses and physician assistants at the school clinic, and they often had me speak to the patients that they thought would really benefit from some additional time. This was something I really cherished. I had so much time to speak with the students and work on their health with them. I worked with patients that were facing diabetes diagnosis before graduation and would meet with them weekly to plan meals. I saw students could not afford three square meals a day and we talked about how to still get the nutrients that were necessary. I talked with moms that were trying to provide for themselves and their children and managing their health at the same time. I could very often see the benefits of the one on one time that we had and could see their growth throughout the year.

As I started medical school, I knew that this was something I wanted to continue. I wanted to be able to speak with my patients. I knew more than ever before that what happened outside the clinic was very important to health inside the clinic. I had heard so many stories about doctors barely getting to speak with their patients and rushing to conduct appointments in 20 minutes. By the end of my time as a health educator I already knew I was coming to medical school at UIC, and I was so excited to start medical school! But I also was starting to have doubts about if I would still be able to have time to meet with patients and treat them holistically, and more than just a set of medical complaints.

I was so excited to be a part of the PCM program for this very reason. It was amazing to know that there were other physicians that were also passionate about working with patients. Through this program, I have worked with an amazing Family Medicine physician who has mentored me on how to speak with patients and learn about their history and past, while still staying on task and working on one issue at a time.

One of the most rewarding moments this year was working with a new patient who was coming in because she was unsatisfied with her older doctor and had many conditions she was managing. While she was seeing an Ophthalmologist for her eye conditions, she wanted a checkup and to speak further about diabetes management and hypertension. I went to speak with the patient first, and what primarily began as a conversation about her health and why she as in that day, it very quickly moved onto her life. She told me about how she was struggling to work because of her eye conditions and that her grown children had all moved far away, which she was struggling with. As we talked further, I could see her opening up to me and feeling more comfortable in also telling me about her medication habits and disease control. Making her comfortable was allowing me to gather better information about her health, and to know

her better. When my preceptor came to the room, I could fill her in, and she was also able to ask similar questions and see what the main issues to tackle in that day were. While it was not possible to take care of every issue all at once, I knew that we had built a relationship and would be able to help the patient with all her health needs. This reminded me of my old days as a health educator where I could spend a long time working with my patients.

As we finished up the visit, I stayed in the room to walk the patient out. After my preceptor left the room, the patient turned to me and whispered, "I like her." I smiled because I liked her too.

Hansika Narayanan
2016-2017 M1 Scholar



I approach the front door of a grayish building labeled University of Illinois Mile Square Health Clinic: South Shore. As I cradle my white coat and stethoscope in my left hand, I yank at the door handle with my right. It won't open. Before I even get a chance to check my phone to see if I had the wrong day or time, the door opens a few inches and an older gentleman in a blue security uniform ushers me inside. I introduce myself to the security guard and he directs me toward a door on the right, past a full waiting room of patients. The waiting room is packed at 8:45. What is this? My preceptor arrived slightly after me and smoothly danced around my awkwardness as she donned her coat and inspected her printed schedule.

The first patient I spoke to that day was my continuity patient; I was to elicit a complete history while my preceptor saw a walk-in appointment. As I knocked gently on the door, a rush of nervousness passed over me. You've talked to her before, she's chill don't worry. I open the exam room door to see my patient, an 81-year-old woman sitting in a chair next to the exam table. I introduce myself, and she laughs, "I know who you are." I began to talk about the materials I had prepared for her: a booklet of exercises she can perform at home in a chair. She asked if any of them involved her lying on the ground because she has trouble getting herself up. I reassured her and demonstrated a few of the exercises for her. We discussed her daily diet and changes she could make to lower her sodium intake.

As we were finishing up, my preceptor entered the room. She elaborated on what having a PCM student entails. "We have had trouble keeping your blood pressure under control, and I have tried changing your medications, you've gone to see the cardiologist but none of it seems to be working." My preceptor explained that she thinks our patient's blood pressure problem lies in her lifestyle. She explained that I, as a PCM student, was there to collaborate with this patient to help her make changes and improve her health. The patient agreed, and after the physical exam we were talking about our plans for Thanksgiving. As we all made our way down the hallway toward the exit, my patient put her arm on my shoulder and said, "We're in this together." I couldn't help but think she was right. While she and I are very different people, I am learning from her just as much as she is learning from me. Six weeks later, when I found out that the patient's blood pressure had improved at her next visit, I was so pumped. With my help, the patient was reminded to make small changes in her life, which will, hopefully, make a huge difference in her health.

Tamara Nunez
2016-2017 M1 Scholar

A Home in the Clinic

As I started the Patient-centered Medicine Scholars Program, I wondered how my definition of PCM would change. To me, it meant seeing things from the patient's perspective. Being raised by my grandma, I saw how health care workers often saw her as a difficult patient. Because she couldn't speak English, they saw her language barrier as a disconnect. As my patient visit began, I felt confident that I would not fit patients into a mold; instead, I could find ways to wear each patient's shoes.

As a first-year medical student in the Outpatient Care Center in Geriatrics, though, many things were foreign to me. Memorizing ages at which colonoscopies were appropriate, asking enough questions to present the HPI and complete history, remembering to check for completion of routine vaccines felt like fitting patients into a mold. It was either check or no check. Yes or no. Referral or not. And when I worked with patients who spoke only Spanish, I felt the disconnect that I had only observed with my grandma and her caregivers. As a student, I wondered how I could put patient-centered medicine into practice.

My preceptor showed me that patient-centered medicine isn't just an abstract theory or buzzword. She showed me that a physician who practices patient-centered medicine constantly keeps the patient's lifestyle and preferences in mind and can counsel accordingly. One of the common perceptions I had of elderly people is that they don't like to change their ways. Once, my grandma refused to use a new 3-tier shelf from Target and insisted on using her old pink tub for her dental items. It was only when my dad showed her that dental items could be put into the shelves that she started using them.

Dr. Z similarly treated patients as if they were her family. When a patient refused to buy hearing aids due to cost, Dr. Z thought outside of the box. She recommended a "Pockettalk" walkie talkie – a more affordable option. Immediately, the patient refused. "What is a PocketTalker? I don't have hearing problems! I don't have money for that!" Instead of dropping the suggestion, Dr. Z made sure to look up the price and brand on her computer to give to the patient, who seemed more open to the idea. This is just one of many examples in which Dr. Z thought from the patient's angle to provide a unique solution. Truly, she demonstrated to patient-centered care involves both the patient and physician working together very carefully and thoroughly.

I saw too that patients preferred patient-centered care. Many patients came to the clinic specifically seeking care in Geriatrics, feeling misunderstood by their former practitioners who didn't address their personal concerns. Each patient came in with a specific complaint, although some hid them. I learned that the clinic team plays an important role in making the patient comfortable enough to share their worries. Everyone from registration staff to nurses to the physician played a role in the patient's decision to return. All staff had the choice to see

the patient as just another visitor, or a regular family member that needed to be heard. Everything from how the resident took notes to how the physician coordinated tasks to team members left an impression on one new patient, who followed through with his referrals and returned to our clinic because he felt carefully cared for. Patient-centered medicine is not only important for physicians to practice, but for patients to fight for and receive.

Overall, I feel strongly that patient-centered care is an important—and relatively novel—way of practicing medicine. In my final IPC visit, I had the privilege of going on a home visit. Seeing the patient in his own home, surrounded by his own plants and foods, gave me a complete story and picture to words from a report; examining him on his own couch instead of a hospital bed kept him relaxed. However, patient-centered medicine doesn't have to be at home. An elderly woman once told me that when you get old, the only things that are "happenin'" are grocery store and doctors' visits. As a medical student who hopes to apply what I've learned in PCM, I hope I can make a doctor's visit feel like another home for patients.

Patricia Lee

2016-2017 M1 Scholar



The Importance of Rapport

When I first met Mr. S, it was only the second time he had seen Dr. S my IPC preceptor at Mile Square Health Center. Before seeing my PCM preceptor, Mr. S had changed providers frequently, even noting that he had seen 13 different providers over the past year. Given this history, my PCM preceptor and I were uncertain if we would see Mr. S again after his visit. I attempted to call him between appointments but unfortunately was unable to get through. With that, I assumed Mr. S was uninterested in following up at the clinic.

However, at my next IPC visit, Mr. S was there, on time for his appointment. Over the course of the year, I was present at four of Mr. S's follow-up appointments with my PCM preceptor. He noted at each of his appointments that he usually doesn't maintain relationships with providers, and that in the past, he hasn't liked the physicians he has interacted with. With my PCM preceptor, however, he felt differently; the fact that the clinic and I called between visits made Mr. S feel that he was cared for, and Mr. S felt more motivated to come to his appointments when he felt his doctor was invested in supporting him.

Mr. S's reaction to my preceptor's care struck me. While understanding that the patient-doctor relationship is important to develop, I had not thought it would be a strong enough motivator to alter the feelings of a patient who, from the beginning, stated that the majority of his encounters with the medical field were negative. However, many of us know this to be inherently true; I myself have avoided following up with providers because I felt they did not listen to or fully address my concerns.

My experience through the longitudinal patient experience in the PCM Scholars Program demonstrated to me the power of building rapport and trust with patients. Given the medical field's varied history in humanely caring for certain patient populations, establishing one's office and practice as a space for compassion, listening, and mutual decision-making is crucial. Each medical encounter serves as an opportunity to earn patient trust and buy-in or drive patients away from treatments and information they would be unable to access otherwise. I am glad to have had this experience that reinforced the value of interpersonal relationships in the medical field, and I hope to carry this understanding forward throughout the rest of my medical education and future practice.

Samara Albazzaz
2016-2017 M1 Scholar



Learning from
patients

My favorite part of participating in the PCM program has been the continuity of care I experienced with my assigned patient. For the past 6 months, I have accompanied my continuity patient to many of her appointments. Because of several co-morbid conditions, she essentially visits the UIH Outpatient Care Center 1-2 times per week. Despite her illnesses, my continuity patient is upbeat, humorous, and sees the positive in everything. Following each of her appointments, we would sit in the lounge area of the hospital and converse while we waited for her ride. We initially talked about safe subjects like the weather and family, but soon progressed to discussing methods for her to follow the advice given by her healthcare team.

For example, one of the more difficult appointments I was privy to was with her nephrologist. Her physician reminded her that if she didn't start focusing on eating healthy and exercising, her kidney disease may progress to the point of requiring dialysis. My patient was clearly shaken by this, although she has heard it before. After the appointment, we discussed the nephrologist's suggestions, and how she could work to achieve those goals. We talked about free senior exercise programs she had utilized in the past through the YMCA and discussed why she stopped going to those programs. She admitted that there was nothing other than laziness that was preventing her from participating. In fact, when she participated in these exercise programs in the past, she recalls feeling energized and happy after each session. I lightly pressured her that if it is easy for her to access the YMCA, she should motivate herself to attend the sessions. Her sister was present during this talk, so I hoped she would further pressure my patient to go to the YMCA.

It seemed like my patient had taken the physician's advice to heart—the next time I spoke with her, she indicated she had begun to take walks in her neighborhood and eat more fruits and vegetables. I was surprised at how happy and relieved I was that she had decided to take these steps. The connection I made with her showed me how valuable continuity is—both for the patient and the physician. My experience with the PCM program and my continuity patient has given me the skills and confidence to form a connection with patients and establish rapport with them.

Martina Gabra

2012-2013 M1 Scholar

Positive

It didn't matter
Who, what, where, why, how or when
It was here to stay

The diagnosis
A permanent part of life
Positive always

And she was able
To stay positive despite
Negativity

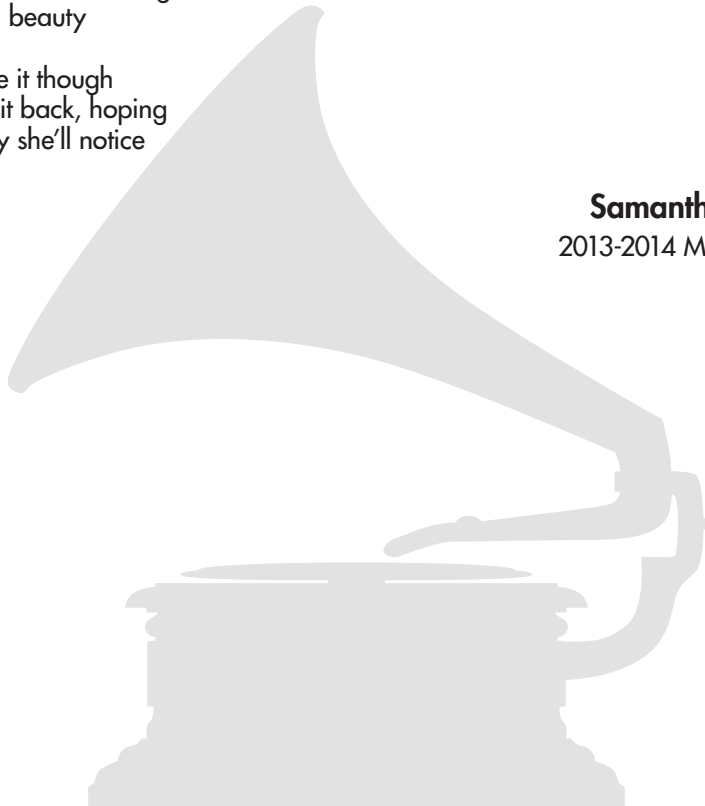
Most would have been scared
Or angry at his deceit
For passing disease

She remained smiling
Always thinking of her son
And of her future

I have to wonder
If she notices her strength
Bravery, beauty

I can see it though
I mirror it back, hoping
One day she'll notice

Samantha Glass
2013-2014 M1 Scholar



Little by Little

The M1 year has been an adventure. If someone had told me on Day 1 everything I would have to learn and do throughout the year, I would have told them they were crazy...and then quietly disappeared into a room to panic. Over time, however, I have come to learn not to look too far ahead. Everything you learn in medical school and beyond builds on itself, and if you consistently just take baby steps (well, large baby steps) along the way, you will be amazed when you look back and realize how much you have learned. I keep thinking that one day my brain is going to reach its maximum capacity, but I have yet to reach this point, so in the meantime I will keep stuffing knowledge in between my ears and hope it doesn't leak out.

Of course, at this early stage in my medical training, most of this knowledge stuffing has taken place in the classroom (and late nights before exams). In the clinic, my learning has come at a different pace and has primarily been centered on patients. Throughout the course of the year, I have come a long way toward understanding the different situations that patients come from, and how their health affects their lives. In my first couple of clinic visits, I was more concerned about not looking awkward in front of the patient, and I wondered how in four years I would ever be a real-life doctor. But again, it's baby steps. As time went on and I gained more experience talking to patients I realized that they don't care that you are just a medical student, they just want help. Often, just listening to them made a world of difference to them. Such was the case with my continuity patient.

A.W. is a mid-thirties woman with a history of depression. Before going in to meet her for the first time, my preceptor started to tell me a little bit about her, then paused and said, "just go talk with her." In my formulaic mindset of taking HPIs related to the "O.L.D. C.A.R.T." of pain symptoms, I wondered how I would fit this model into a case of depression. But coming into medical school I already had a pretty good background in psychiatry, so I organized a quick outline on a blank sheet of paper and anxiously entered the room. When I sat down and asked her how she was doing, she bombarded me with a storm of information before I could even ask her what was bringing her in. I quickly set my outline aside and tried to absorb everything she had to say. She had been feeling "off" for quite some time. She had been here before and was prescribed an antidepressant, but it wasn't working so she stopped taking it. She didn't have any close friends. She was always tired. She was experiencing memory problems lately and needed to write down notes after she talked on the phone in order to remember what was said. She was worried it would affect her work and that she could lose her job. She could not afford to lose her job. She had a hard time finding joy out of anything.

I scribbled down all the notes I could and repeated back to her everything that I got from her. She then went on to tell me more as her four year-old son proceeded to play with all the contraptions in the room. As a medical student without a list of patients waiting to see me, I had the luxury of spending the extra minutes with her to really hear her side of the story. She obviously had a

lot she wanted to get off her chest, and I think that just being there to listen to her problems in earnest might have made a difference to her that day. I relayed everything to my preceptor, who then prescribed her a new antidepressant and referred her to see a therapist. From this one short visit I felt an instant connection with the patient, despite me not having offered any real advice. Sometimes patients just need to be heard more than anything.

This idea of listening, while simple, is often lost in medicine. We have our charts, our mnemonics, our vast array of knowledge of disease states and treatments, and our queue of patients that have been sitting in the office for over an hour waiting for their turn. And make no mistake; patients come for physicians' clinical expertise, not for their ability to repeat back what the patient says. However, when a medical provider is able to take the extra minutes to hear the patient and see the patient as a human being in his/her environment rather than as a number with disease ABC, that is when the best care can be offered.

So yes, I have learned a lot of factoids in my first eight months of medical school, and many of these will indeed be vital to my clinical practice. But perhaps most invaluable are the lessons that I have learned simply by listening to what the patient has to say.

Jeremy Kruger
2012-2013 M1 Scholar



Two patients remind me of some of the incredible lessons I learned through the PCM Scholar Program. I remember Mrs. F, who first came to the clinic due to problems with her diabetes treatment plan. After years of being dissatisfied with her care, feeling frustrated with the healthcare system, and experiencing diverse side effects from her medications, she worked together with my preceptor on creating a treatment plan that gave her the options she had been seeking for years. On the day I met her, she came to the clinic because she needed a refill on her medications. It was at this time that she said she felt better than ever and was thankful for regaining the life she thought she had lost. It was through this experience, and countless others, that I realized the importance of the partnership between providers and patients on the road to health and wellness. Patient-centered medicine requires a thorough understanding of the patient's needs, values, and preferences; it calls for providers to actively work with patients towards creating treatment plans that incorporate the patient's views and beliefs. Like with Mrs. F, patient-centered medicine can not only restore health, but also faith in the doctor-patient relationship.

I also think of Mrs. G, who came to the clinic for a simple checkup. During her visit, it was discovered that she had several conditions that were affecting her health. Although she wanted to follow the treatment plan provided, Mrs. G was very concerned about the cost of the treatment she needed. She was unemployed, did not have insurance, and had recently received medical bills that she was having trouble paying. It was then that I observed not only the actions of my preceptor, but also the relentless work of an interdisciplinary healthcare team, that provided the support network of services Mrs. G required. I still remember the look of surprise and relief when she was told she could obtain the procedure she needed. It was through this brief but meaningful encounter with Mrs. G that I was reminded of the importance of serving as a voice for patients. Providers are called to serve as patient advocates, someone who will fight for their best interest when they need it the most.

By the time patients walk through the doctor's office door, they have already faced barriers of access to care, lack of financial resources, transportation challenges, long waiting periods, insurance coverage limitations, as well as conflicts with navigating the healthcare system. Throughout my experiences in the PCM program, I have humbly observed how, in the healthcare profession, we are given the unparalleled privilege and opportunity to make a difference in patients' lives. I am aware of this gift every day and know that I will cherish it as I interact with future patients. It is in the space between health and illness where doctors provide a light of hope through treatment and prevention, or a hand to hold in the face of disease.

Ana Mauro

2012-2013 M1 Scholar

Patient's Power

"The game can wait, I'm talking to the doctor," patient DM yelled to his brother, who was wondering why patient DM was missing the hockey game. My PCM continuity patient and I were having a 38-minute phone conversation after I asked him for his thoughts on how doctors can help their patients.

Following my introduction to patient DM, Dr. R moved onto the clinical visit, and asked, "So what's up boss?" Patient DM immediately reached into his Blackhawks canvas bag to pull out a sheet of paper. He showed Dr. R his blood glucose readings with every date and time listed since his last clinical visit. Patient DM was upset because his blood sugar had risen to 150mg/dL twice over the past month as a consequence of new analgesic drugs that he was taking to relieve pain for a pinched nerve in his neck. "I know you told me the medicine might alter my glucose levels, but I just get mad when I see it outside the normal range," patient DM said to Dr. R. Later in the visit, patient DM pulled out a prescription bottle to show Dr. R the medicine that he needed refilled. Without fail, every time patient DM came to Dr. R's office, he brought any bottle, letter, or form relevant to the visit in his Blackhawks canvas bag. He also came with relevant information and questions. It was always clear he was extremely dedicated to his health.

Upon first glance at patient DM's medical chart, however, one wouldn't assume that he is such a good patient. Emphysema, diabetes, a history of pancreas and liver failure would suggest that patient DM is not focused on health conscious behaviors. After realizing this dichotomy, I set out to understand what allowed patient DM to start making healthy decisions. His answer, "two reasons: faith and my brother."

When describing how he quit smoking, patient DM explained that he began to have faith that if he started doing his part by making healthy decisions, then positive outcomes would follow. One instigating force was watching his brother pass away from congestive heart failure after living with severe chronic obstructive pulmonary disease (COPD). Patient DM described, "I had a pack of cigarettes in my hand as I was on my way outside to smoke with my brother when I heard him grasping for air in between coughs. I then crumbled up the pack, threw it in the trash and started believing that if I did my part, then things would fall into place".

Patient DM went through a similar process for all his health behavior improvements. He observed the consequences of poor health decisions and had faith that if he put in the effort he could change. Taking the critical steps to improving health is not possible without knowing what the right choices are. This is where Dr. R was integral in this process and why health education is so important. Patient DM advised me to help my future patients realize the consequences of their actions and to emphasize reflecting on their personal faith and will to live healthy.

JJ Parker
2013-2014 M1 Scholar

Benevolence and Non–Judgmental Care?

Addiction—in many ways it’s a politically charged word.

When I type out the word addict, the reader’s mind is instantly populated with an archetype and a schema of the story I’m about to tell. As a writer, this can be frustrating because the truth behind a real-life event becomes perverted by the very words used to tell it.

For the moment, however, I’m going to side-step this archetype of an addict and indulge in a small but significant story telling aberration. Through the Patient-centered Medicine (PCM) Scholars Program at UIC, which pairs medical students up with patients to follow over the year, there is a particular patient that I’ve gotten to know fairly well. This patient—let’s call him Mr. M—is a chatty young man in his late 20s. In addition to a slew of medical and psychiatric problems, he has a history of drug abuse.

One winter morning, I got a call from the hospital saying that Mr. M had a fracture in his left shoulder as a result of slipping on some ice on his driveway. When his primary care provider and I saw him in the clinic the next day, he was in bad spirits. Mr. M was in a lot of pain. He asked one of the many providers on his care team for pain killers. The provider told him to “hang in there” and “if it gets really bad over the next couple days, we’ll see what we can do.” Several days later, I called Mr. M to see how he was doing. He sounded miserable.

He lamented that he’d been sober for more than 6 months since the “event”, but still no one, including his doctors, trusted him. He told me, “Yes, I used to do drugs. I did them because they felt good, not to ever hurt myself.” The “event” that Mr. M was referring to happened 6 months ago, on a Friday night, when Mr. M took a cocktail of painkillers and ended up in the ER. The incident was dubbed an attempted-suicide, though Mr. M adamantly refuses that label. Mr. M told me that he feels like there’s no one he can go to that trusts him; everyone sees the history of drug abuse in his file and automatically writes him off.

He spoke of this and his pain for about 15 minutes. Then, he paused, presumably with the expectation of some sort of response. What was I supposed to say or even do? It was my second month into medical school, and I could barely recognize half the drugs mentioned in his record, not to mention any of the symptoms and disease etiologies. However, as I thought about it more, I realized this wasn’t really about pathology, pharmacology, physiology or any of the classes we take in medical school.

As an institution, medicine prides itself at making benevolent, non-judgmental care fundamental to its creed. However, somehow Mr. M fell between cracks, and I had the nagging suspicion that this wasn’t an isolated incident. This deeply troubled me. I brought this issue up with a family physician mentor. As I recounted the story to him, he closed his eyes and sighed, nodding in agreement.

He told me that medical schools try their best in incorporating progressive teaching strategies into their curriculum. However, in the scope of ethics and humanities, most schools explain behavior in the context of medical jurisprudence. And though the law is incredibly important, students (even residents and attending physicians) miss out on the practical lessons of benevolence and empathy outside of what is legally required. It's almost like the apocryphal story of an equestrian team that spent months pouring over texts describing how to ride horses. Then, during their first competition, armed with equations governing balance on a horse, not one of them was even able to mount a horse.

The first step in solving any problem is admitting that there is one. Prior to medical school, I had gotten some great advice from a professor I really admired. He told me that at any point in my career, if I found something shocking, strange, or disgusting, I should count it—that is, physically keep track of how many times it happens in a week, a month, or even a year. So, after finishing up my conversation with Mr. M, I spoke with my attending about the situation, and I asked him about the number of patients we see in the clinic with addiction related morbidities. He told me that although it largely depends on the location of the clinic, the clinic in question sees about 100 such patients per month—and that's a conservative estimate. I was shocked.

In many ways, my first year at medical school has taught me a great deal about the struggles that physicians grapple with on a daily basis in an effort to provide the highest quality of care. This has been simultaneously frustrating and enriching. These “tough” situations forced me to step back and re-evaluate my values, my responsibilities as a provider, and the complex interplay between these two as we try to do our best to help those in need.

After seeing many physicians, including my preceptor, skillfully navigate this complexity it reminded me that there is still much to learn, and in spite of what we learn in our basic science classes, there is truly an art to performing medicine. The PCM program has undoubtedly helped me understand what it means to be more “patient-centered” and has been an important steppingstone in developing my skill in the art of medicine.

Birju Rao

2013-2014 M1 Scholar

Can an M1 student be helpful to a patient? This is the question I was asking myself all semester and, quite frankly, wasn't feeling too optimistic about it. That is, until I met Mr. M.

I have had the pleasure of speaking to Mr. M several times on the phone before meeting him in person. To my surprise, I always found myself a little nervous before dialing his phone number. I had been in the work field for more than 6 years and knew how to talk to people. When I took time to reflect on why I felt this way, I realized it was because I felt inadequate. I felt that I couldn't possibly provide any help to my patient. What did I know? My knowledge was limited to histology and the anatomy of the thorax and abdomen. I couldn't actually advise a patient or offer any type of guidance to help them with their medical problems! I didn't even complete Physiology yet.

Another reason for feeling nervous was because our interactions were limited to just phone conversations. Only having that as our method of communication, I did not have access to the non-verbal cues we subconsciously communicate when we interact with one another. I enjoy interacting with people and like to think I'm pretty good at deciphering body language. But a voice on the phone doesn't allow you to observe mannerisms, a blank stare, a fidgety foot, or a sad look.

So, my lack of confidence in my own ability to help Mr. M, coupled with the inability to read his body signals, really made me uncomfortable. But I kept making those calls. I admit, I didn't call for altruistic reasons. I called because I had to figure out when his next appointments were.

Finally, the day came when I met Mr. M. He was and wasn't what I imagined him to be, all at the same time. I knew he was a Caucasian, middle-aged retiree who had worked on the railroad for 40 years. And he looked like someone who did just that. However, his demeanor was not what I expected. Something seemed to be missing. Like he once had a twinkle in his eyes that was extinguished. His shoulders were slumped. His warm and charismatic true-self peaked through each time he cracked a joke. He struck me as someone who probably had a lot of friends in the rail yard. However, as soon as he finished talking, his shoulders would slump, and the sad look would appear again.

I then noticed that the attending physician was spending extra time with Mr. M. He was taking the time to understand his home life, his social support network, his desires and his concerns. There was a very personal touch to their interaction, like they have been old friends for years. And, surprisingly, Mr. M was very receptive to this. He opened up about his personal life, spoke about a new lady friend, and even embraced the idea of trying a new activity (Tai Chi!).

After my visit with Mr. M, I spoke with the attending physician about his condition. My first question to him was "he's depressed, isn't he?" The answer was obvious. My heart sank. On the phone, I would never have picked up on this. He just sounded tired or winded or just unenthusiastic about our calls. But seeing him and taking in all the social cues made me realize exactly what was going on with him. The attending pointed out that what Mr. M needed the most was someone to talk to.

Then it all clicked. What we lack in clinical expertise can be more than made up for with compassion and time. As M1s, we can provide perhaps the most critical and, unfortunately, rarest type of care, given the current time constraints of our healthcare system – someone who has the time to listen!

With this new sense of understanding, I felt my nervousness dissipate. I no longer felt inadequate in my lack of basic science knowledge and clinical skills. All of that will come with time. Right now, I must take advantage of the time I have and get to know Mr. M (and all the other patients I will have the privilege of encountering). And, perhaps through these conversations, together we can come up with next steps to get him back on a happier, healthier road.

Christiana Shoushtari

2013-2014 M1 Scholar



Empathy

"I know COPD is going to kill me. If I could just be around long enough to see my grandkids become who they want to be, that would be enough. I want to quit smoking so I can do that." Sixty-one is too young to have to take such a hard-nosed view of your own mortality and hope for a good bargain. I thought I could be helpful. Armed with good-will and tempered with some little knowledge, I hoped that I might help her make that change. I read up on behavioral change models and made phone calls of support. Yet, I did not make the difference that I hoped. The fact that I couldn't leaves me with a mix of humility and frustration. But mostly, I just feel empathy for having to make that bargain, for wanting to change so badly yet not being able to. It is a very human state.

We humans

We humans are frail beings.
We grow old and our bodies wither.
The weight of life grinds our bones
Leaving us creaky and stiff.

We humans are resilient beings.
Sometimes soft and supple
Sometimes sinewy and tough
Molded by our lives yet immutably whole.

Daniel Parsons-Moss

2013-2014 M1 Scholar



More than Labs

As a PCM scholar, I had the unique opportunity to work closely with patients and spend more time with them than most physicians. Instead of the quick 15 minute interview that so many physicians are pressured to adhere to, I was able to spend as much time as I wanted with the patient. This allowed me to get to know the patient on a more personal level, and it allowed me to understand all the different factors outside of the clinic that could be affecting their health.

One patient was the epitome of reasons why patient-centered care is so necessary. The patient, who had a history of hypertension and hypothyroidism, came in with high blood pressure and low T4 levels. For any physician, it would be easy to simply treat the lab values; she should increase both the thyroid and hypertension medication to bring the patient's levels back to normal. However, if that had been the course of action, we would have missed the true reasons why the patient's levels were abnormal.

Because I had the time to talk to the patient as a person and not as lab values, I learned that she had just started a new job, and it had been an extremely stressful past couple of months. In fact, when I looked at the patient's blood pressure measurements taken during her visits since she had started her job, they had steadily increased and directly correlated with her time at work. So, although a physician may objectively look at a patient's increase in hypertension as either a lack of compliance or a worsening condition, there is often much more to it. In the case of this patient, there were personal circumstances that were affecting the patient's health. By having a patient-centered mentality and focusing on all attributes that can affect a patient's health, we were able to determine the root cause for this patient's symptoms and tailor a treatment plan that not only treated her abnormal lab values, but also treated the root causes of her symptoms.

Through this patient and many more, I learned the importance of being patient-centered during every medical encounter. In a time-constrained and congested medical system, it is imperative to contextualize the care of every patient. Through PCM, I learned that patient-centered care is more likely to treat the root causes of a patient's symptoms, and by doing so, we as physicians can increase compliance, improve outcomes, and lessen the likelihood of return visits. Using patient-centered care, physicians can both improve the health of their patients and strengthen the bond between the patient and the physician.

Joshua Muniz

2014-2015 M1 Scholar

To My Dearest First (Living) Patient

Thank you for everything you have taught me. You've opened my eyes to the healthcare needs and disparities experienced by my community's elderly population. You've witnessed the death of siblings, parents, ex-husbands; you've even been disregarded as an old senile woman, "the crazy lady next door who should be institutionalized," and yet you still dress fashionably, with your beautiful hats and trendy boots, and stroll around downtown with a huge smile on your face. You've made me laugh countless times and called me your "advocate." Still, I'd like you to realize that you've taught me more than you could imagine. You've taught me that every patient has a wonder of stories to tell; however, these stories will only be told if I, as a physician-in-training, slow down to take a breath and truly listen to my patient.

Thank you.

Yuri Zermeno

2014-2015 M1 Scholar



From Student to Patient

Thank you, friendly face
For reminding me how to be more open,
For teaching me to listen,
For showing me what gratitude looks like
despite circumstances that I could not dream of facing.

Thank you, teacher
For giving me the encouragement to learn about a disease process that was
foreign, daunting, and unmanageable,
For encouraging discussion,
For answering my most intimate questions,
despite knowing that I would be stunned by answers beyond my imagination.

Thank you, colleague
For working with me to find a solution
For sharing your daily struggles, your successes
For being positive, motivating, and kind
despite circumstances outside of my control and outcomes unknown to us both.

Thank you, from a friend.

Note from the author: This poem was written as a thank you to my wonderful
PCM Patient, whom I followed during my M1 year.

J. Jaros
2015-2016 M1 Scholar



First, at Last

Oddly enough, the most striking encounter I look back upon wasn't about "health" in the strictest sense. Amidst patient visits with doctor's notes and school physicals, the one I remember clearest revolved around a housing form.

It was the fourth appointment of the afternoon. I had been sent in to check the patient's vitals. After I fumbled my way through taking blood pressure, the nurse took over and I stood in the back. The nurse asked, "what brings you in today?" The patient responded with mumbled words marked by inconsolable crying. As the nurse tried to comfort her, I quickly ran into another room to bring back a box of tissues. As the patient slowly regained her composure my preceptor and I spent a lot of time listening to her story.

She revealed a past of drug addiction and hardship. She told us that her current living situation was instrumental to her maintaining 4 years off of drugs, and she needed a doctor's signature saying that she'd be able to continue residing there. This patient was so worried that she wouldn't get the signature in time. She'd been trying and failing to get an appointment scheduled, so she'd been carrying this fear for over a week. All of the hope she had for the future rested on that day's visit. The significance of the form is easy to misunderstand. To her, the form was a lifeline off the streets and into a sanctuary. It would allow her to maintain relationships with people that encouraged her to rebuild herself. They say, "you are company you keep," and she had made us well aware that this company was her salvation. Thankfully, the form was signed, and her worry was finally alleviated. I was glad to see her happy and calm after the ordeal she had sustained.

However, the moment I really treasure came after the form was signed. I had five minutes alone with the patient when my preceptor went to go make a copy of the form. In those five minutes, I developed the first real connection I've had with a patient. We talked about her past of incarceration and homelessness. I teared up when she told me she'd lost two kids on the streets and that she'd keep me in her prayers as I was so young and had a bright future ahead. We talked about how she'd turned her life around and how incarceration never addressed the root cause of her addiction and homelessness. She told me all about the support that helped her rise above her past and how she was paying this support forward to others. I learned that she was slowly saving up bits of her paycheck for something that meant a lot to her.

Priyanka Patel

2015-2016 M1 Scholar

Beyond Clinic Visits

Patient Centered Medicine or PCM is gradually becoming the cornerstone of patient care in medicine. However, I didn't recognize its importance until I became involved with the PCM program. It was something I took for granted as I failed to realize its importance to medicine. Quite often we consider treating the disease as the biggest priority all while failing to recognize the social determinants of health that are contributing to the patient's health. It is more than just writing a prescription and sending the patient home and expecting them to follow-up. Much less thought is given to what happens to the patient after they leave the clinic/hospital. Luckily, I had the opportunity to witness this first-hand through the two patients that I followed over the course of 8 months. Both are females in their 60s. The stark contrast of their experiences provided me with valuable lessons. I'd like to refer to them as Mrs. X and Mrs. Y.

I bring up these two patients as I became an integral part of their lives. I knew about their lives in detail and accompanied them for their medical appointments. Couple of months into this program I completely lost contact of Mrs. X. I couldn't contact her by phone. I even showed up to her scheduled appointments but in vain as she was never there. I reached out to my mentor about it but he too failed to reach her. Mrs. Y on the other hand was always punctual with her appointments. She knew I was a student and as such never missed a chance to teach me important aspects of a patient's life. She ran into some trouble with acquiring medical equipment and I was able to assist her with that. Both women were willing to comply with the medical plan of care. However, the defining aspect of their health was their economic status. One had the time and resources to be there for her appointments while the other did not. They both are on Medicare so affording proper care was never a concern for them.

As aspiring physicians, and even those already practicing medicine, time is a luxury. It is one patient after the other and in this viscous cycle we rarely get a chance to look beyond diagnosis and treatment. We may not realize if the patient can follow-up on his/her next appointment, or if they were successful in acquiring the medication or the necessary treatments prescribed to them. We may forget that they don't know the system as well as we do. No matter how hard we study or what specialty we go into, equal care for all patients is not possible until we fail to address these social determinants of health. Understanding the patient's concerns from their perspective will always be integral to healthcare no matter if one is in family medicine or surgery. That is what PCM is all about - patient care by taking into consideration the patient's personal values and hardships, and available resources. My PCM preceptor helped me realize that social determinants of health can impede the management of a patient's medical plan of care. I now believe that true patient care goes beyond the clinic visits.

Parth Savsani

2016-2017 M1 Scholar

As medical students, we have a laundry list of classes, exams, expectations, and requirements that must be met before we have the honor of calling ourselves “doctors”. From the beginning, we are expected to understand the complexities of the human body and explain what happens when something goes awry. We are enrolled in an endless list of classes and spend hours upon hours trying to make sense of the overwhelming mysteries of the human body, while neglecting our own. While so much time and energy are spent on mastering the “science” aspect of medicine, little emphasis seems to be placed on learning and mastering the skill, the “art”, of being a holistic healer. Little importance is placed on truly learning what it means to take care of our patients in a holistic, spiritual, and physical manner. As my first year of medical school soon draws to an end, I can say that while many of my basic sciences courses introduced me to the intricate connections between body systems, very few of them taught me how to be culturally sensitive and compassionate in clinic. In fact, the PCM Scholars Program served as an introduction to the art of medicine and practicing patient-centered care.

Reflecting on my experiences in clinic with my PCM preceptor, I have come to understand that our patients are our best teachers when it comes to learning how to become the best healthcare provider we can be. While our basic science courses lay the foundation for understanding how the human body works, our patients remind us what it means to be human, which we easily forget after spending hours locked up in a dungeon studying away. After a long exam week, I would always look forward to going to clinic. I would immediately feel refreshed with the warm embrace of an elderly patient, smile of a newborn, and the mundane conversations shared both in English and Spanish. These simple humanistic acts were a daily reminder of why I wanted to pursue a career in the medical field.

Besides learning how to practice the art of medicine, many of the patients I encountered in clinic reminded me that our role as physicians is limited, which was a hard lesson for me to learn. On my first clinic day, my PCM preceptor and I walked into the room of one of her continuity patients. His wife and little girl were present in the room. The patient was there for a routine checkup for his diabetes. Unfortunately, his diabetes wasn’t getting any better; in fact, he was beginning to show signs of kidney failure. “Why haven’t you seen the nephrologist I recommended for you?” “Es que doctora, no puedo faltar mi trabajo.” Hearing the patient explain to the doctor that he could not see the nephrologist because of work immediately reminded me of my own mother and father, who would also neglect their health because they could only miss so many days at the factory, they worked in. After further counseling, my PCM preceptor and I stepped outside of the room and asked me if I could establish continuity of care with the patient. “Of course!” After explaining to him and his wife what my role as a student working with them would be, the patient broke down in tears explaining how hard it has been for him as his family to manage his diabetes on top of living in a country that was not their own. I was deeply moved by his words and fought back to hold the tears. “No se preocupen, yo

estoy aquí para ayudarles con cualquier cosa que necesiten.” After exchanging contact information and assuring them that I was there to help them in anything they needed, I felt a huge responsibility on my shoulders and was determined to do everything I could to help him and his family manage his care.

Throughout my time in clinic, I assisted them with his FMLA paperwork and encouraged him and his wife to make an appointment with the nephrologist, which was a success. However, although we followed up a few times both in clinic and through the phone, I lost absolute contact with both him and his wife. I would try reaching out to them through phone but would immediately be sent to voicemail with no response. Although I understand that my role in their care was limited, I still feel at fault for not having another method of contacting them. Did I do something wrong? What could I have done differently? I felt hopeless. I wanted to do everything I could to help him and his family, and I felt like I had failed them. Part of patient-centered medicine is accepting the fact that as physicians we can only do so much. As much as Dr. Rios and I counseled the patient about the importance of exercising and eating well to control his diabetes, we could not control the fact that he had to work all day to provide food for his family, nor could we control the type of food he ate if he lived in food desert.

Practicing medicine requires an understanding of the human body and existence beyond what our basic science courses can teach us. Practicing the art medicine requires of us to empathize, build trust, demonstrate patience and compassion, provide a helping hand, lend a listening ear, and cultivate relationship with our patients both in and outside clinic.

Rosa De La Torre
2016-2017 M1 Scholar



I vividly remember going into the clinic for my very first IPC visit of the year. More specifically, I remember practically begging to any and every holy force in the universe that I wouldn't have to talk to a patient one on one that day. I chalked it up to nerves back then, but looking back, it was simply a lack of confidence – I felt like a kid playing dress up in a white coat and a stethoscope, much less a budding professional.

Naturally, on that very day, my preceptor assigned me my PCM patient that I would follow longitudinally throughout the year. And of course, he recommended that I go in and talk to her for a few minutes and get to know her, just us two. On top of that, he casually stated that she only speaks Spanish – I recall him saying something along the lines of “it should be good practice, good luck!” It seemed my rusty Spanish skills would finally come in handy that day. I remember my hand shaking when I went to knock on the door of the room she was in, thinking to myself, “what am I going to say to this woman? How am I going to carry on a meaningful conversation when I can barely conjugate verbs?”

But upon walking in and greeting this small, sweet, elderly woman, my fears seemed to melt away. She greeted me so warmly and immediately opened up about her life and her health concerns. Quite honestly, I was shocked with the amount she was willing to share with a lowly first year medical student whom she had just met; yet, it made me incredibly invested in her story. I shared in her sorrows, her fears, and her laughter when she lightheartedly poked fun at my lackluster Spanish skills. It made for such an overwhelmingly positive experience that my confidence in working with patients has grown tremendously since that exact day.

I know that not all patients are as amicable as the one I was privileged enough to work with but being able to work with her throughout the year reminded me why I chose to pursue a career in medicine. It truly all comes down to the patient and being able to work with her reminded me that at the end of the day, it will be my duty to make sure that my patients are receiving the highest quality of care possible. Patients put so much trust in us as physicians, thus it is our duty to make sure that it is not misplaced. For this lesson, I am incredibly grateful to my PCM patient, as well as my preceptor for pushing me out of my comfort zone, ultimately allowing me to shatter my own expectations of myself.

Justin Temple

2016-2017 M1 Scholar



realizations

Making Health a Priority

Upon entering the Patient-centered Medicine (PCM) Scholars Program, I was most excited about the opportunity to build a long-term, meaningful relationship with a continuity patient. The prospect of getting to know a patient extremely well, learning about health care from a patient's perspective and developing a patient-centered approach to medicine was exceedingly exciting to me. Therefore, you can imagine my disappointment when my continuity patient—who had expressed interest in the PCM program over the phone—did not show up to her first appointment, nor returned any of my calls to reschedule. At first, I was worried that I might have made a bad impression during our few phone calls that dissuaded her from coming to her appointment. Eventually I gained some perspective and realized this wasn't about me. This was about my patient.

In medicine nowadays, terms like “noncompliant” and “nonadherent” get thrown around quite often when describing patients who don't show up to their appointments, don't take their medications regularly or don't follow their physician's advice. Labeling patients in this way takes the pressure off of us as physicians and insinuates patients are the ones doing something wrong. Ultimately, this does nothing beneficial for our patients. Patient-centered medicine urges physicians to dig deeper, to listen to each patient's story, to respect each patient's background and to work with each patient to construct a treatment plan that is most beneficial for him or her. Some patients have so much going on in their lives, that it makes it difficult for them to make health a priority. This can be frustrating for physicians since we know the importance of maintaining good health. However, thinking about the patient's perspective allows us to respect what they have going on in their life and work with them to tailor their treatment plan to their individual needs.

Thinking back to my patient, I knew she had had her share of health problems in the past and was currently battling depression and dealing with a difficult home life. I can definitely understand how this would make it difficult for her to make it to all of her appointments. My experience with my patient also helped me realize the importance of taking advantage of every single appointment we have with our patients and trying to make the greatest positive difference we can in that time.

Overall, my experience with the PCM Scholars Program and my continuity patient this year has helped me gain a fuller understanding of patient-centered medicine and how to better utilize it in my future as a physician.

Nicole Bronson

2013-2014 M1 Scholar

I was up to my neck in the cold lake water, with a big floating board strapped to my feet, trying to understand the barrage of advice and instruction I was receiving from everyone on the boat right next to me. My morning had been spent learning how to wakeboard and had not been successful thus far. I was getting frustrated and I was about to give up for the day, and I think the driver of the boat could tell. He had been quiet so far, letting the other passengers try to explain what I needed to do to improve my technique. Suddenly he piped up from behind everyone.

"The thing you need to do is hang on just a couple seconds more. Just when you think you can't hold on anymore and you're ready to fall, make yourself hold the rope just a little longer," he told me.

"Okay," I said, all the while thinking, "yeah, whatever dude."

The boat pulled around and I grabbed the rope before it started to pull up the slack. I told them I was ready, they pushed down the throttle, and I found myself about to repeat my 'face smashing into the water' move that I had become pretty proficient in that morning. I remembered what the driver had told me, however, and I held onto the rope instead of letting go and bracing myself for the fall. All of a sudden, I was up out of the water, wakeboarding. I was so excited and unprepared that I quickly lost my balance and fell again, but I had finally done it. I held on just that little bit longer, and it was all I needed to finally wakeboard.

This experience popped into my head earlier this year when I was working with my continuity patient. Mr. W was having trouble getting his blood pressure medication prescription filled since the pharmacy was not accepting his insurance. I needed to help him through this process because often times the health care system can be very difficult to navigate, and Mr. W would tend to get frustrated with the process and give up. But most importantly, he was recovering from a stroke, and if his blood pressure did not decrease from its extremely high level, he was in severe danger of having another one. I needed to help him get his medication, and I needed to do it as soon as possible.

I sat with him at our university pharmacy, spoke on the phone with his local pharmacy, called his old insurance company, and spoke with his new insurance company, each time getting referred to someone else I had already spoken with. Mr. W got frustrated and went home after about an hour of this, and understandably so. It seemed like we were getting nowhere. After a while, I even had to call it quits with the intention of trying again the next day.

I was irritated, but I did not blame these people. Pharmacists and insurance representatives cannot afford to sit on the phone with me for hours at a time working on just one case. Other cases, some even more important, would be piling up in the meantime. And while Mr. W's physician could possibly help out by making a phone call or two, she was in the same boat, already spread way to thin with her current patients to be able to take the time. Not having enough time for each patient is one of the major hurdles health care providers face these

days. I went to bed frustrated with the health care system, second-guessing my decision to pursue a career in this field.

In the morning, I was right back at it, getting passed from pharmacist to insurance representative right back to pharmacist. I was about ready to give up and talk to his physician about pursuing other pathways for obtaining Mr. W's medications when I was finally patched through to someone who knew what Mr. W needed to do. It was so simple; he just needed to call a specific number and ask for a 'coordination of benefits', which would only take a couple of minutes. I relayed the instructions to Mr. W and a couple hours later I got the call that he had his medications in hand. Several weeks later his physician let me know that he had come for a follow up appointment and his blood pressure was very well controlled. I was excited. I had been about to let go of the rope, but I held on just one second longer, and I found success.

If you ask me what makes a good doctor, I will tell you that it is the one who does not give up. He or she asks one more question, tries one more test, makes one more phone call, all so that each of his or her patients not only receives the best care possible, but trusts that their physician will do everything he or she can to ensure the patient is taken care of. This attitude instills in the patients the idea that their physician cares about them as a person and is going to be right by their sides throughout whatever ordeals may come along.

As far as wakeboarding goes, I am still working on the whole turning aspect of it. But I can get up out of the water every time, and if you are having trouble doing the same, just let me know. I have some pretty good advice for you that may not just apply to water sports.

James Swakow
2012-2013 M1 Scholar



Patient, Person, Friend, Sister

She expressed herself in broken hand gestures and half-articulated words. No tears, no self-pity, just a sense of “well s---, what do we do from here?” The left common carotid, blocked by plaque, had thrown a clot to her brain. The stroke left her with Broca’s aphasia and paralysis in her right hand.

But the question – in all her actions, gestures, and attitude – remained: “well s---, what do we do from here?” 57 years old. Mother of two. Wife. Daughter. And now patient. Who was this patient to me?

The preceptor introduced her to me via the patient’s electronic medical chart before entering the room. He knew she would be a good “continuity patient.” Complicated, long-term.

For my part, I was unsure what “continuity patient” meant for me. Would I simply assist during today’s appointment in getting a complete history? Would I accompany the patient to future appointments? How long would I maintain contact with the patient?

In the end, we (the patient and I) worked it out together. Her husband would be our go-between since she could not speak or write. So, I got his contact information, and he readily took on the role of translator.

“Well s---, what do we do from here?” The question started off our relationship. I did not know the answer. I simply took a deep breath and tried to listen as best I could to the details of her medical situation, home situation, life situation....

Even after neurosurgery to clear the remaining 60% blocked artery and rehabilitation to improve speech and recover motor function in her hand, the question hovers between us: “Well s---, what do we do from here?”

I did not realize how much I would appreciate this question in the end. Why? Because it gives me a place in her life; a role. Now we can talk about the diabetes and pre-hypertensive state that led up to the stroke. Now we can address dietary habits and exercise regimens. And now, I can meet her children and her father in addition to her husband. And we can continue to communicate via text, e-mail, and phone.

The question, “Well s---, what do we do from here?” still lingers in the air whenever we meet.

I plan to accompany her to her next and next and next appointment (the very next one being a day after I write this reflection). This computer chart patient has become a person, a friend, and a sister to me. I love her!

Jennifer M. Chertow
2012-2013 M1 Scholar

Practicing Patient–centered Medicine

Patient-centered medicine seems like it should be so easy. The Institute of Medicine defines it as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” If our job as doctors is to respond to the needs of patients in the first place, it shouldn’t be difficult to use a broad definition of needs rather than a narrow one, right?

Not exactly. How do you let patient values guide your clinical decision making when your patient isn’t feeling any different after taking his blood pressure medication and doesn’t see why he should keep taking it? Or when your patient goes to Puerto Rico for a month at a time, and the doctors he sees there change all his medications? What if your patient just doesn’t seem to like you? How do you respond to your patient’s preferences, needs, and values if she doesn’t want to share those things?

Having worked with a patient this year, and having watched my preceptor work with many more, the importance of planting seeds has never seemed more important. We don’t have to do everything in one day, and doing something as simple as making sure a patient has a planner to keep track of upcoming appointments can flower into more visits remembered and better management of health, all through understanding and responding to a need that is not directly related to health.

The words patient and patience both derive from the Latino root “pati,” which means to suffer or to endure. This year, success in patient-centered medicine has come to seem, to me, as reliant on that idea of unwavering commitment over time. Our patients are complicated, and in order to place their preferences, needs, and values on par with ours as physicians, we need to commit to dedicating the time to understand what is important now for our patient, before planting seeds for the future.

Wes Gibbert

2013-2014 M1 Scholar

At the beginning of the year, we all feel happy, filled with new hopes and goals. However, as time progresses, you feel overwhelmed by the amount of material that you need to know. Not even studying everyday can help you to keep up with the classes. There are times in which you ask yourself, "What in the world am I doing here?"

Somewhere in the depth of your mind you remember that you need to do your first PCM visit. Oh man! I have to spend a whole afternoon in the clinic when I have to study for ANATOMY, HISTOLOGY, PHYSIOLOGY and BIOCHEMISTRY. You go to the clinic and shadow your preceptor. You start learning how to take medical history and help translating when needed. As you gain more medical knowledge through your basic science classes and ECM, you are able to understand more of what is going on in the clinic and be more involved in the care of the patients. It is a great experience that reminds you why you are pursuing medicine in the first place and go back to your books with similar feelings as those that you had at the beginning of the year.

Participating in the Patient-centered Medicine (PCM) Scholars Program and giving continued care to one patient for a year reminds you that the health of a patient is not only dependent on finding the right diagnosis and prescribing medication. You also need to understand your patient as an individual and learn more about the environment he/she lives in. It allows you to make the assessment plan that best works for your patient.

Fatima Giron

2013-2014 M1 Scholar



Sometimes It Isn't All about the Chief Complaint

As medical students, we are trained to focus on a patient's chief complaint like a laser beam. We are trained to ask all the right questions beginning with 'what brings you in today' as well as every detail about the patient's life so that we can figure out what is wrong with the patient and make them better. However, sometimes a patient's chief complaint is not necessarily what the patient wants addressed. Being able to walk this fine line might be the reason you get to see your patients for a very long time or never again. Understanding what a patient's chief complaint is and distinguishing it from what the patient wants is one of the skills that I have been very grateful to learn from my preceptor this year, through the PCM program.

On my first day at the clinic, we went to talk to the patient. He said, "you ask the questions and I will do the typing and whenever I see that you are stuck, I will jump in". So, I did all my best to ask all the right questions to help my preceptor come out with the right diagnosis. After taking the complete history and doing the physical examination, he gave the patient his diagnosis. He then turned to the patient and said, "what do you think we should do about it?" Being a naïve medical student, my thoughts were 'you have got to be kidding me'. Then the patient replied, "What are my options?" My preceptor then took the time to explain all the therapeutic options that are available for the patient. It was an eye opening moment.

I have also had the opportunity to work with an incredible couple Mr. and Mrs. T. It is amazing how a combination of medical, social and family support working together can make a great difference in a patient's life. Mr. T was diagnosed with renal failure and hypertension a couple of years back. His wife also has some medical conditions but not as severe as Mr. T.

When I first met the couple at the clinic, I was blown away by how much they were well informed about each other's medical conditions. Mr. T will start to say something but gets stuck and Mrs. T will fill in the details and vice versa. Mr. T goes to dialysis three times a week. He is very proactive about his health and makes it a priority to make sure that all his lab values are within normal values. I have been able to pay them home visits and we have talked at length about their health, past medical history, and their personal lives. It has been a wonderful experience working with them this year and we have developed such a great relationship. I call them from time to time to see how they are doing and also to help them with information that they need. Mr. T. was once on a transplant list a couple of years ago but got dropped because he did not follow up with the transplant team. After a conversation with him at the clinic about a month ago, he is thinking about getting back on the list.

It has been an enriching experience working with the PCM program this year and I look forward to being a part of this great program next year.

Roland T. Njei

2012-2013 M1 Scholar

Resilience

We are taught in our Human Development course that black women as a collective demographic are extraordinarily psychologically resilient. They are more likely to die from breast cancer than any other racial or ethnic group, have an estimated rate of new HIV infections that are twenty times higher than white women, receive some of the poorest health care services in the country – yet exhibit the lowest adult suicide rates. To be completely honest, I often react to such statistics with annoyance. Why don't we focus on socioeconomic status and availability of health care resources instead of sex, race, and ethnicity? Those are the deeper issues, right? When it comes to public health research, my politically correct liberal arts background drives me to ponder why we are still hung up on skin color and as a legitimate factor in quality and accessibility of care.

Well, I'm starting to get it. Although socioeconomic status plays a major role in access to care, what I never realized about many of these statistics before is that even when controlling for income, education level, location, etc., black women are often still suffering considerable health care disadvantages compared to their non-black counterparts. Unfortunately, I have yet to receive a clear explanation of why. What I have seen first-hand in spite of these discouraging statistics, however, is prevalent attitudes of hopefulness, independence, and perseverance among black female patients.

One patient's situation in particular will probably always resonate with me. T. Y. is in her early twenties, about my age, who lives alone and works to support herself. Right away, I noticed that T.Y. is an independent and responsible young woman with a quiet, friendly disposition. She had come to be evaluated for a rather large, potentially infected post-operative wound that should have healed already. Her surgery was months ago, but she had to discontinue follow-up appointments with her surgeon when she had to change jobs and consequently lost her health insurance. She desperately needed to be re-evaluated by her surgeon, but her financial limitations were preventing this. In addition to her surgical needs, T.Y. also has an additional medical condition that requires medical treatment she simply cannot afford. Nevertheless, at the moment, T.Y. takes care of herself in the best ways that she can, hoping that eventually she will find a solution to her medical needs.

What struck me most about T.Y.'s situation is that her surgeon didn't put forth an especially impressive attempt to contact her when she stopped attending her follow-up appointments. While I fully understand that her surgeon probably has many patients to follow-up with and undoubtedly has an incredibly busy schedule, I can't help but think that this whole patient-physician relationship really has to be a reciprocal investment. As medical professionals, we should not be okay with the unexplained absence of a patient under our care. I also couldn't help but wonder whether the situation would have been handled differently had T.Y. been older, wealthier, and not of minority status.

I think that T.Y.'s situation resonates with me because she is my age. I can't imagine having to cope with her hardships, and I especially admire her positive, patient, hopeful attitude. She exudes a level of resilience that I'm almost certain I wouldn't be able to match. I feel incredibly privileged that I will one day be responsible for caring for patients like T.Y. She has inspired me to continue pursuing a career in which I can affect changes that will help the countless other patients facing similar adversities, and I hope that I will be able to empower all of my patients to adopt such a positive perspective on the future of their health.

Lauren Segelhorst
2012-2013 M1 Scholar

Realizations



Redefining Compassion

"You had an abortion. Do you realize what happened?" said her physician. Her mother was incredibly adamant about her daughter having no other chances to become pregnant, so she brought her into the clinic to undergo intrauterine device placement.

"Are you listening to me? Can you tell me what is happening to you today?"

"You are putting that inside of my uterus."

"Okay, look at me while I'm talking to you please. What will it do to you?"

"It's so I don't get pregnant."

"Okay. Are you ready? You took your ibuprofen?"

"Yeah"

This teenager I saw in clinic one day was having an IUD placed inside of her, and she was very nonchalant about it. She didn't seem to take responsibility over her actions, yet she was having a procedure done to her that assumed sexual responsibility. All the while, her mother, in staunch opposition to her daughter's sexual activity, was browsing on Facebook on her cell phone throughout the entire visit.

I was disappointed in meeting a patient who was seemingly unaware of why she was going through a medical procedure. In my mind, every patient undergoing any kind of medical procedure should be as aware as possible about why they are undergoing the procedure, what the benefits and risks of the procedure are, and the social implications of the procedure. However, the girl I saw in clinic that day seemed to have the most superficial understanding of what was going on with her.

While I was disappointed in this patient's behavior, I appreciated how her physician approached the situation. She was honest and straightforward. We normally think of compassion as an essential quality of a physician, and while I would agree, this experience made me rethink the meaning of compassion. Compassion involves understanding an individual patient and treating him or her in a way that influences health behavior in the most positive way. This might involve being harsh towards a teenage girl. A good physician understands the type of communication needed for each individual patient and then performs in that manner. This is truly patient-centered medicine. The patient's physician understood not only the biological and cultural nuances of the patient, but also the patient's individual personality and health behavior. This is critical for a successful patient interaction, and this experience made me rethink how I define the compassion that a physician exhibits towards their patients.

The patient was eight weeks along with her pregnancy before her abortion. Hopefully, the stern attitude her physician had towards her, an important component of compassion, helped her reflect on what those 8 weeks meant.

Megha Shankar

2012-2013 M1 Scholar

I started medical school as a “non-traditional” student, meaning I had not gone straight from college to medical school. For several years I pursued a career in dance, waiting tables to make money. I thought that this experience gave me a leg up. I didn’t have a problem approaching patients; I approached “strangers” all the time. And in many ways, I believe that was helpful. I didn’t have the nervousness approaching my first patient to take a history; I dug right in.

The other, less positive, side of being a non-traditional student is not having been in a full-time academic setting for a long time. I was nervous about the workload and anticipated a rough start as I adjusted. Medical school is an adjustment for most new students, but as one who had been out of school for a while, I thought it would be an even larger adjustment for me. As anyone faced with an enormous workload might do, I attempted to be efficient in my studies. I read review-style books and focused on outlines and lectures that would get me the material I needed in the least amount of time. Mid-year, I noticed something had changed. When I was in college and an instructor used an anecdote to tell a story, I enjoyed it. It made my lectures less dull and helped me remember the material. But now, with so much material, I found myself getting annoyed. If a patient went on a tangent in the middle of taking their history, I was irritated (though I tried not to show it!). I thought, this is a waste of my time. I’m a busy person; just tell me what I need to know to do well in these classes.

This is where PCM made a difference for me. I realized that listening to these stories or anecdotes, even in class, is part of the process; that patients aren’t reduced to bullet points or outlines, their symptoms falling neatly into boxes we can check; that understanding these stories are part of the care of patients. I realized that my strategy to be efficient helps in many ways, but it will fail me in the long run if I don’t learn to listen to the stories.

Anne Henson

2012-2013 M1 Scholar



More after the Jump

There is nothing quite as terrifying as walking into an exam room alone for the first time- sweaty hands, clenching jaw, hoping to remember the mnemonic for the history of present illness. Wait, what was it again? Old parts maybe, old carts... old carts! That is it. Suddenly, your white coat, the one you checked twice for stains before deciding you did not have enough time to wash before Introduction to Patient Care (IPC), feels tight at the seams. And of course, the stethoscope! It does not really fit in the coat pocket, does it? But I don't want to put it around my neck; no, I am not there yet. As if the innocent sign of the profession compensates for the fact that, after practicing numerous times, I still cannot hear the Korotkoff sounds, I knock once, twice, and then jump in.

Technically, the "first time" should be that, a first time. Afterwards, of course, I assumed I would learn to walk into a patient's room with the confidence of all my histology knowledge, introduce myself, and acquire a history with minimal stuttering. However, I have had a fair amount of firsts, and if there is one thing working closely with my Patient-centered Medicine (PCM) mentor has taught me about practicing medicine is that, regardless of the amount of patients one sees, interviews, diagnoses, and treats, many patient encounters will feel like a first time. Therefore, treating these encounters with the preparation and care of a first time is an intuitive way to remain engaged in patient-centered practices.

With time, we will all gain the confidence of our preceptors, and our hands will hopefully get less sweaty. Confidence, however, is a relative term. In medicine, I like to think it refers to the certainty in one's skills, the willingness to make and address mistakes, and the ability to establish a connection with another human being.

Valeria Valbuena
2013-2014 M1 Scholar



Deeper Worlds

What struck me in the Patient-centered Medicine (PCM) Scholars program, and what I found most valuable, was the realness, the gritty texture of the patients who we've so often seen as statistics or headlines.

It's easy to flatten people out, make their lives and stories into a neat, ordered HPI; turn their fears, grievances, anguish into a yes/no checklist. And it's necessary. But how much of the intangible do we lose with our 2D renderings?

I met a Mexican patient recently with an intracerebral hemorrhage affecting his right cerebellum from which he was still recovering. He was also undocumented. I thought about how many categories he'd fit into: a great example for ipsilateral dysmetria caused by a cerebellar lesion; a perfect anecdote for President Obama to include in remarks about immigration. And I thought about the countless others in his exact position that suddenly became extremely real and urgent to me, as if their outlines had been filled in. I read the paper and I listen to the arguments of immigration advocates and I agree with them and I sympathize and then I move on. My compassion is genuine, but not all encompassing; I am not haunted.

I met this patient a week ago and I still sometimes wonder how he's doing. Part of me is extremely frustrated at the relative powerlessness each of us has in the face of the machine. But I also think that's a good thing – a reminder to us of the real people and emotions that can easily get lost. So many of our patients will represent abstractions, biological or political. Some will resonate more with us than others. What's important is that they do and we don't forget that representations aren't substitutes, but windows into deeper worlds.

Ivy Zhu

2013-2014 M1 Scholar



Obesity Pep Talks

One of our professors told a story about how they went to the Doctor's office to get a refill, only to receive a 20-minute lecture on their weight by a Resident Physician. They walked out of the office both irritated and empty handed, their refill not completed. "I know I need to lose weight!" our professor recounted, but at that juncture, and in that manner, it simply was not the appropriate discussion.

As I listened to the story, I was horrified. That's exactly what I do at PCM... every time...with every patient. Though my patients were too kind to correct my misjudgment, looking back I realized that the discussion was not productive, only a reminder of an issue that they were already aware of. I always suggested diet and exercise, a mantra they had undoubtedly heard many times before, but did not think to ask or explore what prevented them from adhering to a regimen.

Obesity has always intrigued me because it seems like a pathology or addiction. However you qualify it that has the potential to be solved. All we need is diet and exercise, I thought. My father was an obesity researcher for many years at a pharmaceutical giant and was amongst the first batch of scientists to explore the potential of Leptin as a weight loss solution. They quickly realized that Leptin served as a protective mechanism from starvation, not obesity. Continuing the family tradition, I looked at Leptin levels in a population undergoing nutritional transition. They were high; the threshold of the hormones' usefulness had been breached. Leptin's inability to help our bodies stave off obesity is an elegant allegory for our inability to attack this problem. We have built an environment that makes it nearly impossible for humans to lose weight after they break a certain threshold. Our bodies are simply not wired to work at these new environmental frontiers we have crossed into.

As I attended each clinical visit with my preceptor at Jeffery and 71st I realized more than ever before how complex the issue of obesity and food addiction is. Nearly every adult patient I saw was overweight or obese, not surprising in one of Chicago's lowest income neighborhoods. Unlike other addictive substances like alcohol and tobacco, unhealthy foods are ubiquitously and inexpensively available in all neighborhoods, without age restriction. While an alcoholic can go cold turkey in the hopes of progressing towards freedom, a food addict does not have that option. We need food. We have surrounded people with an addicting substance necessary to survive with little alternative and hope they can avoid it with self-discipline and internal motivation.

I don't have a comprehensive solution, but I do have a better understanding of the problem. I won't be giving patients 20 minutes lectures on how important it is for them to lose weight on our first encounter. I won't suggest they buy alternative and more expensive foods outside of their budget and believe that I've accomplished something. I will, however, be more acutely aware of how pervasive the problem of obesity is, and I will continue to work towards understanding a solution in the future.

Omar Jamil

2014-2015 M1 Scholar

For the better part of two decades, Mr. K was incarcerated, his world confined by walls and fences under the constant watch of guards. He dealt with a lack of autonomy regarding the healthcare he received, a harsh reality since he suffered from severe knee pain brought on by osteoarthritis. But Mr. K was recently released from prison, and for the first time in 18 years, he had the ability to make decisions regarding his diet, daily activities and the manner in which he wanted to manage his pain. This transition, however, was met with certain obstacles, including the absence of family from his life. He admitted starting the process of coming to term with some of these issues and working to building a support system with several newfound friends at his shelter. With an opportunity to have his independence restored, Mr. K began taking the first few steps in the journey of rejoining society. But navigating a health care system, which seemingly grows more complex every day, was an issue that was becoming especially burdensome, keeping him from moving forward with his life.

Mr. K's history showed that he had osteoarthritis in his knees, pain from which limited his mobility and disrupted his daily activities. The day I first saw Mr. K, he did not have a formal chief complaint. The pain in his knees was bothering him, but he already knew how to best deal with it. Outside of needing some labs completed, his visit was not related to obtaining a diagnosis, medication or lifestyle advice. His primary concern was to understand why he his insurance stopped covering hyaluronic acid injection therapy, which alleviated his pain and allowed him to prevent undergoing undesired knee replacement surgery. His frustration was clear, and his energy drained from not getting any information from countless phone calls and written letters. His goal was clear, he wanted to learn how navigate a system that had become completely foreign to him.

My preceptor began working with Mr. K by explaining to him the subtle, but important, details of his insurance plan. Explaining that his injection therapy required a primary care physician's referral, she approved his specialty therapy. Rather than simply providing the signature, however, my preceptor was diligent in walking Mr. K through her thoughts and the process required for him to receive his therapy and see his specialist physicians. This was the most apparent example of patient-centered medicine I observed while working with my preceptor. Mr. K never directly asked for this information, she knew that in order for him to successfully transition, meet his health needs and perform daily activities without pain, Mr. K required a certain level of knowledge of how to navigate an intimidating and confusing system.

Sometimes the epicenter of a doctor-patient relationship exists outside of the realm of diagnoses and prescriptions. This was one such instance, in which the healthcare professional's role involved more than providing lifestyle advice or diagnosing an illness. Guiding Mr. K. through the health care system and allowing him to take control of his pain management were critical features of his visit that allowed him to restore his autonomy. Although Mr. K had many more issues to confront, empowering him to manage his health issues allowed him to start taking the necessary steps towards a lifestyle he desired.

Bhavik Patel

2014-2015 M1 Scholar

Oh the patients you'll see!

I arrived at my first PCM visit feeling nervous and a bit out of place.
"What if I'm bad at this?" I wondered with a worried look on my face.
I walked up to my first patient room reciting OLD CARTS in my head
and entered to find a smiling patient seated on the exam bed.

Shaking her hand, I proceeded to take out my notebook and pen.
"I'm just here to ask a couple of questions. So tell me, how have you been?"
She told me about the diabetes she was diagnosed with three years ago;
In the past week, however, her blood sugar had been dangerously low.

We talked about stressors, about diet and exercise.
"It's been hard to eat regular meals, no matter how hard I try!"
The doctor came in after to review what we had discussed,
I observed their interaction and saw how my preceptor gained her patient's trust.

The three of us came up with ideas our patient would like,
all in an effort to avoid those blood sugar spikes.
It was a team effort to search for a cure,
But she could do it and of that we were all sure.

Shani Chibber
2014-2015 M1 Scholar



Cooking Up Continuity

"But we just got to know one another," she said. On the second (and last) clinic visit I attended with my continuity patient, I had to explain that summer break was approaching, and I would not be at her future appointments. Although I had only met her twice in person, we exchanged phone numbers and emails addresses, I texted her reminders the night before her appointments, and sent her diabetic-friendly recipes I came across from my usual cooking blog scavenging.

Before we met, she did not show up to two scheduled appointments in a row, citing "life chaos" as her reasoning. The first time we met she explained much of her complicated social history and concurrent struggles dealing with her chronic diabetes and mental illness. She seemed (understandably) frustrated that sticking herself three times a day with a needle wasn't improving her HbA1c. She seemed defeated, not imagining that she might have other treatment options. Her doctor, my mentor, helped her change treatment regimens. She exchanged one tongue-twistingly-named drug for another and adjusted the daily dose. I helped in the only way I could, with inspiration for healthy comestibles and motivational support.

She showed up early to both subsequent appointments and seemed motivated to improve. She asked questions about her medications and verified that she understood the directions properly.

After an entire year of a steady HbA1c above 10, two months after meeting her, her HbA1c declined to 8.2. I can't say that I was the reason she started coming to her appointments or gained motivation to improve. However, she knew that I was focused on her improvement, and that I held her accountable: "Girl, you were on me last night," she joked about the text I sent the night before her appointment. She and I both appreciated the continuity, and I believe her improvement can, in part, be attributed to it. I felt guilty telling her that I probably wouldn't see her again and determined to make sure my future patients perceive me as someone who will support them, hold them accountable, and make the process towards good health seem achievable

Katherine Reifler
2014-2015 M1 Scholar

Though a science, an art in its practice

At some of my medical school interviews, I was asked to explain if in my opinion medicine is an art or a science. The biology major, college senior that I was at the time, I argued that medicine is predominantly a science. Surely, medical students are taught basic science and are trained to apply this knowledge of science to treat patients and cure them of disease. I was convinced that without the appropriate knowledge, the issues patients present with cannot be properly addressed.

It has been slightly over a year since my interview, and quite a lot of my understanding of medicine has changed in this short time span. I have spent countless hours this past year memorizing the location of every muscle and vessel in the body, the physiology, and the biochemistry of all the metabolic pathways. Strikingly, however, none of this information was directly applicable to seeing patients alongside my preceptor throughout the year. The patients that I had the privilege of seeing in clinic were not concerned with how well I knew the Krebs cycle or all of the muscles of the limb. To them, of most importance were my undivided attention and the free-of-judgement environment that I tried to establish in the room. While working with my preceptor throughout the year, my skills to communicate with patients were the most important at identifying the issue at hand and promoting compliance with the chosen treatment. I have come to realize that though medicine is indeed advanced by scientific study, its practicing is by far an art that is difficult to master.

As a first year medical student in the PCM program, I learned to appreciate that the art of medicine urges physicians to understand many other factors that may play a role in a patient's recovery, thus transforming them from technicians in medicine into true physicians. The art of medicine is patient centered: it ensures care that is respectful and tailored to the individual as a whole. I am beyond grateful to be a part of the PCM Scholars program, which has been encouraging me to practice the art of medicine since the first day of my medical education.

Clara Stelman

2015-2016 M1 Scholar



To My Future Doctor

My Future Doctor,

I know that you have three more patients waiting in other rooms right now, six more waiting in the lobby. I have seen you walk past the door for the past thirty minutes. Once, you popped your head in for about two seconds to tell me that you will be with me in about fifteen minutes. It's been over thirty minutes and I'm still waiting.

I am not upset. I know that you will eventually come in, and I promise not to take up too much of your time. All I ask is that you listen to me, to my story. Please don't look me at as another name, another disease that you have to treat. I know that you don't have much time, but all I ask is that you sit and look at me as a person.

Yes, I know that my blood sugar is high but that's because I stopped taking my insulin. I felt myself getting dizzy and lightheaded whenever I take it since I don't have much food to eat at home. I know you want me to eat more fruits and vegetables, but I really don't have much of a choice. They're so expensive at the corner store and the nearest grocery store is nearly a 30-minute bus ride away.

Yes, I know that I need to exercise more but I think I get enough exercise at work. I run around all day cleaning rooms. I don't think I have the energy to go to the gym after work and besides, there isn't a gym nearby.

No, I haven't made that appointment with that heart specialist that you wanted me to see. I'm so busy and I cannot get time off from work. I also have to take care of my aging mother and that takes up my time too. I know you're starting to feel frustrated with me but please, do not give up on me.

I just need a little bit of your time, to just sit and listen to my story and hopefully, understand my story too. Maybe then we can work together to finding a solution. Because sometimes, another pill is the last thing I need. Unless they have a pill that can cure all these social ills, you're the only one that can truly help me.

Your Future Patient

Krishna Constantino
2015-2016 M1 Scholar

What Happens After Death?

Death isn't something that is new to me or an abstract idea seen acted out in Hollywood movies. Having worked in healthcare for the past 7 years prior to medical school, I have experienced my fair share of deaths; from a sudden code blue in a hospital, a bloodied code trauma in the ER, to an elderly man taking his last breathes on hospice while holding his children's hands. They were mothers and fathers, brothers and sisters, and sons and daughters. Some of them were accomplished and decorated Army Veterans, while others were math teachers, and a few of them victims of Alzheimer's. Some of them have left a lasting impression so much as I still remember their first and last name, yet others were merely strangers whose paths I crossed at the end of their journey. Working at a hospital, I would often help nurses and physicians prepare the body after death so the family could mourn. As the family went into the room and closed the door behind them, all you could hear were their deep and broken cries.

Until now, I have never really given thought to what these individuals leave behind. Who they leave behind. Not until I took on the responsibility of caring for a patient whose chief complaint was grief. Her "symptoms" included an emotionally destructive force that consumed her with grief, so much so, that she could not breathe at times. Anxiety attacks and chronic depression that paralyzed her for days. Sometimes contemplating suicide hoping it would put her out of the heart ache pain and maybe bring her and her husband together once more. I've never thought grief could present as such an extreme and life threatening condition. I've never considered the damage that is dealt to everyone surrounding one individual as their life ends. I've never really understood what happens after.

Helping this patient through bereavement and the grieving process over the past year has shown me that the pain of an individual in their last moments do not end with their life. But are instead passed on to their loved ones to bare. As I've helped this patient through different methods of grieving over the past year, I have learned one important lesson. The void and pain experienced with loss of a loved one doesn't ever go away. It just gets more manageable as time begins to heal the fractured heart. Therefore, antidepressants, and SSRIs only fix the superficial problem of loss. To fix the untreatable deeper heart ache felt from loss likely needs a deeper treatment.

A possible solution is adopting "mindfulness." I know this sounds like a bunch of meditation rubbish but hear me out. Mindfulness means maintaining a moment-by-moment awareness of our thoughts, feelings, sensations, and surrounding environment. A larger part of mindfulness also involves acceptance. When we practice mindfulness, our thoughts tune into what we're sensing in the present moment rather than dwelling on the past or fearing the future. And more so, why we're feeling what we're feeling, so we can better find a solution for healing. Some techniques used in achieving this mainly help in slowing down racing thoughts, such as deep breathing and meditation. Even something so simple as

counting your breaths or steps while walking can help take away attention from negative thoughts. Thoughts that often consume a grief struck individual causing depression.

Managing a patient experiencing chronic depression and deepened grief over the past year has shown me what goes on behind those "closed doors" of mourning. Such an experience will undoubtedly change the way I practice medicine, and more importantly, how I deal with death and their loved ones. I know that more often than not, they will need help as they begin the grieving process. With the invaluable experience this patient has given me at such a young point of my medical career, I hope to use her experiences to help others along the way. In that the pain never truly goes away. The void never truly disappears. But as time progresses, the pain is more manageable, and the void is filled with happy memories of ones who are lost.

Faisal Akram

2015-2016 M1 Scholar



Learning the Art

Whenever mentors ask about my experiences as a student, I tell them the details of my courses, and reliably, they respond that they barely remember anything from their first year of medical school. While I know that's not entirely true, as the foundation we're building now will serve to uphold all of our future studies, I hope when I think back on my first year of medical school, if I've forgotten everything else, I at least remember the lessons I learned from the patients I met.

More than anything, I've been introduced to "the art" of medicine. And I can't say I have that exactly mastered. As a medical student, I strive to develop a sequence for patient visits that's second nature; something that flows naturally from start to finish, follows a logic, and doesn't leave any pertinent questions unanswered. But life doesn't exist in a sequence, easily packaged and taught to well-intended, enthusiastic medical students. Listening to a patient talk about their worries and concerns, their experiences and their lives never has yet to fit my checklist. These conversations bounce freely from thought to thought, rarely includes the questions I think to ask next and often throws my practiced and well-tuned chronology out the window. And so be it. Rather than reacting in frustration, it humbly reminds me what's most important.

As much time as I've spent over the last year learning the nuances of biochemistry, or the progression of a disease, I have to learn the nuances, lives and priorities of patients with as much care, attention to detail, and ability to pick up on what's unspoken. To work as a team to carefully balance our time together between talking and listening and thinking and discussing. Like any refined art, it's all rooted in the mastery of basic skills, new perspectives, and growth; so I'll keep practicing my scales and brushstrokes, for the rest of my career.

Lindsay Waggerman
2015-2016 M1 Scholar



Relationships

Before coming to medical school, I spent a year earning a master's degree in health psychology. We talked a lot about the importance of communication in a healthcare setting, and particularly in the doctor-patient relationship. Most studies conclude that there is a need to better educate medical students and doctors in communication skills. Unfortunately, there is little in the literature to address how such skills might be taught. Upon entering UIC, I was thrilled to learn of a program dedicated to the practice of patient-centered medicine.

The PCM lunch and learn sessions have emphasized the fact that better patient-doctor relationships lead to better healthcare outcomes. We have also discussed the strength of social and environmental factors in predicting disease etiology and treatment outcomes. In order to appreciate these variables in any given individual, physicians must know their patient well.

My preceptor has demonstrated that patient-centered care requires a relationship-centered approach. I have never seen a doctor make herself equal with a patient. My preceptor achieves a basis of equality in every encounter I have witnessed. She does these two ways, by humanizing herself, and by humanizing others. My preceptor spends time exchanging nonmedical life experiences with her patients – cultural and familial conflicts, the challenges of child rearing, the love of food. She also displays an attractive sense of self-deprecating humor; cracking jokes, for example, at her tendency to run late or at a frustration with technology. At the same time, she empowers her patients through a strength based approach. She routinely acknowledges patients' hard work – paid or unpaid – and complements patients' own sense of humor, as well as their strength of character. In turn, I have learned, patients are affectionate towards my preceptor. They trust her and entrust in her. In the context of this mutual honesty and affection, "shared decision making" flows naturally.

At some point or another, we are introduced with the topic of "physician burnout". I read several years ago that a critical way for physicians to prevent burnout is to cultivate greater empathy towards their patients. At first, this seemed counterintuitive to me. Heavier emotional investment, I thought, how would this alleviate compassion fatigue? This year, I've had a glimpse of just how.

Relationships are mutual; that is, not only patients benefit from a fruitful relationship with their doctors. My preceptor is happy; her relationships with patients are fulfilling and energizing. A physician's authenticity and genuine communication might not just be important for a patient's health, but also for her own.

Claire Daniel

2016-2017 M1 Scholar

Dog Room

My clinic visit started off like any other day. Dr. J moving through one animal-themed room at a time – Cat, Panda, Fish, Dog... Me trailing behind, blending inconspicuously into the wallpaper while occasionally trying to offer a tidbit of medical information whenever able.

As often happens, the patients started to blur after the first few hours. Dr. J routine questions for the parents went in one ear and barely came out the other. Cat – How long has C.A. been coughing? Panda – Has A.G. had his flu shot? Fish – Has H.Y. been eating normally? Until... Dog – How's S.H. been adjusting to the states?

As Dr. June and I settled in Dog Room, I was immediately arrested by S.H.'s gaze. Though only 15 months old, S.H.'s eyes reflected the soul of a much older child – dark, unfaltering, and apprehensive. I turned my attention to Dr. J's conversation with the mother. I found out S.H. had been adopted from South Asia a month ago and was transitioning to life with her new family in a new country. The mother had many questions about S.H.'s skin dryness, sleeping patterns, eating habits, frequent cries of distress, and apparent mistrust towards her new father. Dr. J, as always, provided expert medical advice, calming the mother's fears and reassuring her that S.H. was healthy and within the normal ranges of development.

The mother finished asking her questions. Dr. J proceeded to ask some questions of his own. It was only when she stopped talking that I noticed her baggy eyes, her stretched out shirt, and messy hair. Her eyes and hands constantly jumping to S.H., making sure she felt comfortable, safe, and loved. I realized that even though S.H. was the patient today – even though she was the one receiving shots and check-ups – her mother was just as much in need of human attention and comfort.

Dr. J must have sensed it, too. He reached out, held both her hands in his, and said "You're doing a great job."

I knew that this statement was more than cliché pep talk, more than just the right words to say at the right time. And so did Sarah's mother. Dr. J had adopted 4 children from abroad, as was evident through his many family pictures along the walls and in the rooms of the clinic. And it was his personal experience that he started to share with S.H.'s mother that seemed to comfort and encourage her, more than the medical knowledge he had shared previously.

It was an otherwise standard visit, but I especially appreciated this interaction that Dr. J had with his patient. As someone who wants to pursue pediatrics in the future, I learned the value of tending to the entire family's needs – not just focusing on the child's medical conditions as an isolated case. By addressing not only the child's medical needs, but also meeting the mother where she was and providing emotional support, Dr. J embodied the practice of patient-centered

medicine. I have an incredibly long way to go before I can practice any kind of medicine. But in the meantime, I hope to embrace and embody Dr. J's traits of respect and empathy – and to one day exemplify those traits in my own practice.

In Ae Jang

2016-2017 M1 Scholar

Realizations



I am here to listen as you explain your symptoms
I am here to treat the pains in your body
I am here to help as you navigate the health care system
I am here to be a constant presence when you are in need
I am here to advocate for your health rights
I am here to inspire you to reach your goals
I am here as a shoulder to cry on when you need to express sadness
I am here as a comforting smile letting you know that everything will be ok
I am here for you to share your deepest concerns with
I am here for you to expose your most vulnerable experiences
I am here as your confidant keeping your secrets safe
I am here because I want the best for you
I am here as your young doctor
I am here to learn from you

Alicia Pugh
2016-2017 M1 Scholar





I think that all individuals need to feel connected in some way or another in order to feel a sense of contentment and peace. Looking at this picture, you may feel touched by the raw emotion that can be seen as the inner selves of the individuals long to connect with one another. In this state, these individuals are in their most vulnerable form. While many people may not see it at first glance, this photo can be applied to the nature in which physicians must care for their patients. What many physicians tend to overlook, is that patients come to them in their most vulnerable states – whether their sickness is by nature psychological, emotional, and/or physical. In this regard, they are seeking to make a connection with their physician.

This connection can only be made if a physician is truly looking at providing patient care on all levels – addressing struggles that patients may experience in a scope that extends beyond a superficial treatment of physical symptoms. If the physician fails to provide this holistic care to their patients – a trusting relationship cannot be built and a limit is placed on the benefit that a patient can gain from this encounter. But if the physician can truly appreciate the vulnerable state in which the patient is seeking care and strive to treat the patient in a manner that prioritizes the overall well-being of the individual – there are no boundaries to the impact that can be made on a patient's life.

There is no limit to the positive progress that can be achieved. There is no quantifying the positive effect that can be made through a fulfilling, trusting relationship between a patient and physician – because it becomes immeasurable. And this is the true impact of patient-centered medicine.

Realizations

Zainab Shirazi

2016-2017 M1 Scholar

Shattering the Rose-Colored Lenses

If you've ever met me, you know I'm a pretty upbeat and optimistic person. And if you've really gotten to know me, you'd say that my first statement is quite an understatement. I love to try to find a positive spin to every situation, especially when it might help someone else cope or feel better. I mull over memories over and over until I find a redeeming quality to them. Whether this quality is a life lesson or a happy ending, I find ways to idealize my memories. In writing this memoir, I could easily select the best moments of my Patient-centered Medicine (PCM) Program visits and further glorify them with this narrative. I could tell you all about how rewarding it was to meet my continuity patients for the first time and sit with them for well over an hour. I could trail on and on about all about the different patients I've already had a chance to see, the wonderful medical assistants and nurses I have had time to chat with, and the stellar guidance that my preceptor has offered me over the course of this year. Instead, I'm going to do something a bit out of character. I'm going to write about my worst visit. I'm going to remember those feelings of discomfort, that lack of confidence that I felt that day. I want to challenge myself to let the memory stand out on its own, without my carefully censored filter and analysis. By reflecting on this day, I hope to catch my past mistakes and not repeat them. I believe this will help me grow as a compassionate human being and future physician. So let the story begin:

It was my fifth visit in the clinic. I had seen my continuity patients twice already. We had scheduled this day to be our third visit. In previous meetings, I had established rapport and we (my preceptor, patients, and I) had established a care-plan. In theory, the day should have been a perfect visit. I was so eager to follow-up and see some positive results that I practically skipped into clinic that day.

I came in, set my stuff down, tidied up my outfit, and set out to find my preceptor. I tracked down the medical assistant working with him and discovered he was still with a patient. No problem. I tagged along with the medical assistant as she began to prep the rooms for the following patients. As we hustled from room to room, I chatted with her as I always do, offering to help and taking in her stories. Something was off that day though. As I walked with her, she stumbled and caught herself. She frantically apologized, explaining that the day has been long and busy. On top of that, she was worried that she was getting sick. I spent a few more minutes with her and noticed that her eyes were watery, and her gait still seemed weak. I didn't really know what else to do other than tell her that I was sorry she was feeling unwell and offer to help with preparing a room. She thanked me, but there was nothing else either of us could do to make her day better at that moment.

Finally, my preceptor emerged from the patient room and greeted me. We discussed my goals for the day and decided that seeing my continuity patients should be my top priority. However, my patients weren't scheduled to come in for another twenty minutes. Since we knew that I hadn't mastered taking a complete history and presenting in less than half an hour, we decided it would be best if I

waited to see them as soon as they came in.

Twenty minutes came and went, and there was still no sign of my patients. I started to feel restless. I had already rewritten the notes from the previous visit, brainstormed topics to follow-up with, and imagined a plethora of scenarios of how the visit would go. To calm my nerves, I offered to help the medical assistant again. I just wanted to start feeling productive and useful. However, she had already finished setting up all the rooms and admitting patients. On top of that, she appeared to be feeling even worse than earlier, but once again, there was nothing I could do other than offer my sympathy. I felt helpless and useless.

Five minutes later and my continuity patients still had not arrived. I debated going to see another patient that the medical assistant had deemed “student-friendly.” I couldn’t. What if my patients were just running late? What if they had to wait for me? My preceptor and I had agreed that my continuity patients were my top priority! I mustered the little confidence I had remaining and sent my patients a text, hoping that they would respond quickly. I didn’t even know if this action was appropriate, but I just had to do something. Another ten minutes went by as I sat in a corner of the clinic, refreshing the patient list every minute or so, hoping that my patients’ names will be highlighted, indicating that they checked in. No luck. My preceptor finished up with his patient and I updated him on the situation. He seemed unfazed, as I’m sure any seasoned physician would be. Still, it bothered me that they didn’t come. They were my patients. Not that the other patients were somehow less important. But these were my patients, they wouldn’t bail on me. We were a team! Of all the scenarios I had sat anticipating for the last half an hour, this was the only one I hadn’t prepared for. It didn’t matter that I had spent a good portion of my undergrad as a Poverty Studies minor, reading about lack of access to transportation or missed primary care visit appointments due to socioeconomically related reasons. They were my patients, so they had to come. We had to overcome the textbook statistics, not become one. Right?

At this point, despair overtook my sense of helplessness. I felt beyond frustrated, not at my patients, but rather at the situation. Not only did I feel useless, but I just didn’t know what to do. How could I be productive without feeling like I was in everybody’s way? My preceptor had a busy day remaining and even with my patients not here, we were still behind schedule. I didn’t want to waste his time trying to work through my feelings out loud. These things happen and I just had to move on. So I quickly updated him on the situation, and I told him about texting my patients. He seemed surprised that I had texted them since some patients find that unprofessional. Instead, he suggested that I call them from the clinic phone to see why they missed the appointment and record it. Yes! After more than half an hour in clinic, I was finally going to be of some help to someone!

Once again, I sat back down in what had become my corner. I opened the patient chart and found a note I could record my call on. Maybe the day would turn around after all! I dialed in the number and waited. Nothing, no tone, no

sounds at all. I tried again, and again nothing. I tried moving to a different phone and yet again nothing. Finally, I had to admit to myself that I didn't know what I was doing. I looked over at the medical assistant I was working with and she hardly seemed awake. She had a moment of peace to just rest and I didn't want to take that from her. Instead, I found one of the other medical assistants I had worked with before and asked for help. They chuckled at me. How silly that I didn't know that I need to press nine (or seven...looks like I'll be asking for the number again in the future) to dial out. I laughed along, hoping to mask how helpless I felt.

At this point I had been in clinic for about an hour and accomplished nothing. Absolutely nothing. I could have studied at least two lectures in this time, maybe even seen two patients, worked out, called my parents to catch up, taken a nap, meditated, etc. Medical school has taught me to use every minute of my day as efficiently as possible and here I had just wasted an hour by feeling useless and out of place.

Finally, I managed to get the call to go through. A raspy, friendly voice greeted me. It was my patient! She remembered who I was after my quick introduction and I began asking her about her health, wellbeing, and why she had missed the appointment. However, her voice was muffled by the static from the phone and it was difficult to make out exactly what she was saying. I tried to ask her to clarify a few points, but the discussion seemed to escape me as she mentioned her back pain, then her knee, and then some third problem I couldn't quite catch. I tried to ask about the appointment and scheduling a new one. She brushed me off, saying that her niece had canceled the current one and that she'd figure it out. I tried to check if she had gone to her other appointments that we had recommended in her care plan. I wanted to know if she thought her health and problems were improving. However, the phone continued to cut out and she began to talk about her niece and family and finally said that she had to go. I stared at the notes I had been taking on my paper, trying to make sense of what was relevant for the electronic note. I had finally done something, but still felt so unsure of myself and helpless.

As I was finishing up my note, I noticed a group of two to three medical assistants approach the medical assistant I was working with. At this point, she still seemed very sick and tired. At first, I thought the medical assistants came to check on her. Instead, they began to criticize her quite harshly for grabbing some wrong paperwork and placing a patient in the wrong examination room. I didn't know how to feel. I felt sorry that she wasn't feeling well, and I knew she was doing her best, but I knew the other medical assistants as well. They were frustrated because paperwork was getting lost and mixed up and their doctors' patients were being sent to my preceptor's rooms. My medical assistant nodded her head weakly as the whirlwind of demands and complaints were directed at her. Finally, the other medical assistants left. I turned to try and say anything to try to help or cheer her up, but before I could say anything, she stood up and walked towards the bathroom sniffing softly. Maybe everyone was having a bad day? How could we care about our patients if we couldn't even look out for one another? In addition to feeling useless myself, I just started to feel



disenchanted. Disenchanted by the healthcare system, disappointed in the lack of kindness I had seen, and just sad that I didn't know how to make more of a positive difference.

The rest of my visit was less eventful. I had the opportunity to see one patient and chat with them. Even as I collected their history and then presented it to my preceptor, I couldn't fully shake the ugly feelings that had been stewing in me for the first half of the visit. I had a chance to accompany the patient to the lab part of the clinic to complete some testing and then finished dictating the complete history to my preceptor. Three hours were up, and my shift was over. Normally, I'd be eager to work well past the necessary three hours and see another patient. Instead, I just felt exhausted, even though I hadn't done much of anything at all. I just wanted to go home and put this day behind me. My preceptor had a moment to sign off on my log, but that was it. Patients were waiting and he didn't have the luxury of calling it a day.

And that was it. It was a short day in which I felt that I wasn't very helpful to anyone. So how do I handle this memory to learn from it while not transforming it to be something that it was not? Normally, I would be tempted to tell myself, "Look you had a rough day, but you still called your patient and cared about other people." But that doesn't feel completely honest to me. Sure, it was a rough day and despite it I still tried to be kind. That's not my takeaway lesson though. You may have caught it, but I focused on myself a lot that day. I focused on how I felt, how awful the day was for me, how my expectations weren't met by reality. I let every imperfect part of the day wear me down. Although I was aware of my feelings, I wasn't mindful of them. I let myself get consumed in negativity. I'm ashamed that I was in denial about my patients not showing up. Even more so, I'm angry at myself for not worrying that maybe something bad had happened to my patients. Instead, I just wallowed in sadness about how my expectation of the day was shattered. I wasn't patient-centered. I focused on what I thought my goals should be for the day instead of focusing on how I could be present and in-the-moment both for my continuity patients and for the patient I did see.

If I could redo the day, I would make some big changes. First, I would have called or texted my continuity patients the day before to remind them of their appointment. Not only would that have been a nice reminder to make them feel cared for, but it was my responsibility to double-check that the appointment still worked for them. Now I know that I won't be calling every patient personally the day before once I am a physician, but in this situation, I think it would have been the right thing to do. I remember thinking about texting them just to double check and shying away from it. It was more comfortable for me to assume that everything would just work out instead of being proactive. Secondly, if I was once again in a situation where I felt like I was sitting and doing nothing for half an hour, I would be more direct about wanting to see other patients and help him and the medical team. During other visits, we would work as a team where he worked with one patient as I interviewed a "student friendly" patient by myself. By the time he finished with the first patient, I would be ready to present the next patient to him. Usually this worked, but that day it didn't. Either I should

have found ways to make peace with waiting patiently for my patients or I could have suggested shadowing along with him until the patients checked in. In any case, I should have found a way to keep myself from wallowing in my emotions. Lastly, while I don't agree with how the medical team spoke to one another that day, I think that by being judgmental of the interaction, I lost a compassionate side to myself. Although I believe that better care will come from a team that gets along, becoming "disenchanted" by the situation reduced my ability for compassion. Instead of judging, I should have just continued to be as kind as I could and continue to work to get along with my team to the best of my ability. I should lead with kindness, but also understand that there are limitations to what I can do individually. I could start by being kind to myself and forgiving myself for not being able to make everyone's day better. Especially in cases of patients that have received bad news, my goal shouldn't be to cheer them up because that is what I like to do, but to be honest and provide the support that they need to help them move forward.

Ultimately, in reflecting on this memory, I see that there is still a lot that I don't know and that I will always face some limitations to my own ability. I don't think that admitting that is something I should feel ashamed about. Instead, I want to conclude my first year of medical school by trying to be mindful of these feelings and this uncertainty. Things won't go the way I expect them to and that's fine. "Sugar-coating" memories may help me feel better about myself, but I should not do this at the expense of honest reflections that provide opportunities for growth.

And now as I finish my thoughts, I realize something. During my "best" visits, I didn't have to think so hard about what went into patient-centered care. It came naturally. It was easy to be entirely focused and devoted to my patients because I wasn't worried about myself and my own shortcomings. Realizing and dealing with my limitations during patient care will probably be one of the hardest challenges that I will face in the coming years. I'm grateful for this experience as I've learned a lot about myself and set higher standards for how I want to behave. I may not have all the answers yet, but I look forward to my next few years of medical school as I continue to challenge myself to be a patient-centered and compassionate physician through the PCM Scholars Program.

Ivana Surjanec
2016-2017 M1 Scholar



M2 & M4 Scholar Reflections



geriatrics

There is No Time like the Past, Present and Future

At the beginning the school year, I had a myriad of questions about the types of issues that I might encounter when working with the elderly. My thoughts primarily revolved around the specific medical conditions that I had learned about in my basic science classes that primarily affect the elderly. I wondered what types of health issues my client would have:

Would she feel isolated from friends and family?
 Would she be depressed?
 Would she have declining cognitive abilities?
 Would she have dementia?
 Would she have Alzheimer's?
 Would she have cancer?
 Would she have a terminal illness?
 Would she have physical limitations?
 Would she be able to hear me?
 Would she be managing chronic illnesses?
 Would she be taking a variety of medicines?

So, with these questions and more flitting through my mind, I entered my client's room, just as I would an examination room in a clinic. I diligently applied the "OLD CARTS" mnemonic, compiled a history of present illness, took a complete history, and completed a review of systems. Then, after asking all of my usual interview questions, I was left with an unexpected luxury: time. Unlike all of my previous clinical experiences, I had as much time as I wanted to actually get to know my client as a person beyond the usual social history questions and I could explore more complex and complete questions than usually possible in a traditional medical setting, addressing my client's past and present.

What was her life like growing up in Chicago?
 What was it like to raise three kids as a working mother?
 How did she balance motherhood and working full time?
 What were her daily struggles?
 What were her favorite memories of raising her children?
 Where are her favorite places to go in the city?
 How does she spend her days?
 What does she enjoy doing most?
 What is the best thing about retirement?
 What are her current goals?

Having this luxurious time allowed me to learn things about my client that would not normally be included in a Medical Record. I discovered the full and very active life my client had lived. I learned about her family, her profession, her dreams and her struggles. It was through these non-standard questions that I learned that she had spent her entire life taking care of her family and others, and that she devoted little time to herself before retirement. As a result, now, after years of tending to other people, she finds herself alone, inactive, and at a loss for what to do with her time. Health conditions that had started years earlier have been exacerbated by her current reality. The more I got to know my

client's past and present, the more I wondered about my role in her future. After a lifetime of focus on others, how could I help her take care of herself? What could I do to make a positive impact on her life? Would I actually be able to help her improve her health? Would I be able to help her make a positive change in her life?

This was my first experience in handling issues beyond "present" illness, and in focusing on longitudinal care. Looking to help her improve her health on a broader scale, rather than just treating the immediate problem, opened my eyes to the real struggles the elderly enters when their lives change drastically. In working with my client, I recognized that as she aged, she had fallen into a cycle of chronic pain leading to inactivity, then to boredom, then to eating, then to weight gain, and finally, to more pain. Getting out of a cycle like this is extremely difficult by oneself, so continued support and encouragement is essential to achieve positive change. Because I was able to meet with my client once a month and get to know her on a deeper, personal level, I recognized that some of my initial attempts to help her break the cycle were not effective. By attending doctor's appointments with her, I was able to observe the approaches that her physicians used to address her major health issues. And, during each appointment I went to, I was able to contribute to her doctor's understanding of her situation through my knowledge of her health issues and her attitudes and willingness to change to better her health and extend her life.

Over the course of the year, I learned from my experience the importance of considering a patient's past, present and future in order to achieve the best health outcome for the circumstances.

Rebecca Krasaeath
2012-2013 M2 Scholar



Throughout her life, M has held many different jobs in a wide variety of fields. She has experienced what, by her account, seems to be almost constant change in both her personal and work life and has always been able to easily adjust and almost relish her many new experiences and circumstances. The first change that seems to have provided a true obstacle is the transition to living at HOME. When financial and health circumstances led her to move to HOME a one year ago, she clearly experienced a profound loss of sense of self. She was forced to give up her ceramics repair business due to lack of space and also had to get rid of many of her possessions, which was clearly distressing for her. Since living at HOME, she spends much of her time in bed, rarely leaving her room. When talking to her about how she would like her life to be, she expressed interest in a number of activities from painting to singing at church to ceramic repair and even poetry but seems to fear these activities due to her perception that she is no longer good at them due to her age. When I encouraged her to try participating anyway, she would usually respond positively and seem excited about resuming an old hobby, but when I would return several weeks later nothing would have changed and she would often deny that she had genuinely been interested in the activity in the first place.

In addition to frustration with activities she used to enjoy, M has also struggled to make meaningful connections with other residents at HOME. She seems to interact more easily and freely with younger people, delighting in sharing stories of her life and her passions. With individuals in her own age group, she is far more restricted and often seemingly unintentionally creates adversarial situations. In many ways, she identifies herself as an elderly person (perceptions of her own declining health and physical abilities), but a part of her is determined to avoid fully identifying with her age group. I believe her frustration with what she has lost with aging makes it difficult for her to feel that she fits at HOME.

What I took away from my experience with M is the debilitating and likely under recognized frustration many elderly individuals feel with the inevitable changes that accompany aging. While major issues like memory loss or serious illness are clearly recognized as serious impairments to seniors' quality of life, the smaller decrements seen in vision, coordination, or even changes in voice can be deeply distressing to patients. Many individuals (like M) may have trouble fully admitting their own frustration, which doesn't allow those around them to help them find a way of working around these new challenges so that they can still participate in activities that bring them joy. I also now more clearly see that the elderly, or really any patient who seems frustrated, angry, or struggling to fit into a new setting, may be experiencing an unrecognized health related challenge. I believe that through PCM I have learned to delve deeper into patients' life stories to understand not only their major medical issues, but also the seemingly more minor troubles that may be having a great impact on their ability to lead a happy and productive life.

Melissa Bryan

2012-2013 M2 Scholar

Just a Guy

My patient's a guy just like me.

A long time ago his wrinkles held tight,
his old eyes saw precisely, he could jump really high!
He was a young guy, just like me.

He twirled girls at the disco, and cheered ball with his buds.
And from his mother and father and brothers, stole hugs.
And he signed up for war because of conviction,
then back on these shores, trimmed heads to perfection.
And he was a young guy who dreamed, just like me.

And like how ink drains from ballpoint pen tubes,
so his dark scalp became spent and turned pale like the moon.
His blood turned sweet like soda, and his waist donned bigger pants.
And when work was too much, he settled for stamps.
He showed me his tray; it holds pills like they're candy;
The green one's for L4 pain that flogs him when standing.
And he lives alone now, his mother's hugs are long gone.
And it has been decades since he Hustled 'til dawn.

But he jokes! He complains, and he hollers at Obama.
And he crafts feathered sculptures and enjoys teary dramas.
Though true time beats body every time these two duels,
He's not an old guy, just a guy that's old.
A guy just like me.

Alex Merlo

2012-2013 M2 Scholar

My experience showed me how difficult it is to initiate any lifestyle modification in a patient. Being in the geriatrics focus group, I was assigned to a 65 year-old woman. She was obese and had type 2 diabetes, high blood pressure and psoriasis.

Although it was apparent, she kept herself mentally busy, spending her day making jewelry and reading, she admitted to not leaving her assisted living home more than once a week or really getting any type of physical activity. When I proceeded to mention to her that any modest physical activity could greatly benefit her health, and that some of her health conditions are related to her weight and inactivity, she was already completely knowledgeable of the situation. She fully understood all her maladies even more than I did, and how they precipitated from her lifestyle. She knew that just a little bit of physical activity could go a long way in her situation. When asking my patient why she didn't leave the building to even just go for a small walk, she would immediately admit that it's just because she "feels lazy". I asked about any physical constraints imposed on her. Again, she truthfully admitted to me that the only reason she doesn't leave is because she can't gather up the motivation.

To be honest, it makes me sad that while I am progressing and moving through all these phases in my life and education, all that my patient is doing is sitting in her room. By the time I see my patient the next month, so much has happened to me and I've experienced so many things, for better or worse. She hasn't left the 5th floor of her building more than a couple of times.

Knowing that my patient's inactivity is physically hurting her isn't the most painful thing I see. I want to see her live more in the time she has left. I kept reminding my patient that there were many things to do and see that are very accessible for her. She again admitted that, although she wanted to experience the world also, she just couldn't gather the motivation to leave. I'll leave this program with a small sense of guilt. While I run from class to the library, work as hard as I can, and strive to live to the fullest in the brief time I have free, I frequently picture my patient just sitting in her room and I wonder if there was anything I could have done to change that just a little.

Matthew Morrow

2012-2013 M2 Scholar

The first thing I noticed when I met A.R. was that his room was totally devoid of any decorations: no pictures, no paintings, no posters, no calendars or curtains; his room was bare except for a bed, a chest of drawers and a TV. But as I soon discovered, the room was symptomatic of how A.R. felt.

You see, A.R. had gone through a lot in the past couple of years. He had lost his wife of 30 years to pancreatic cancer, and a few months before had just suffered two minor strokes so that he could no longer care for himself completely. A few months before we met, A.R. had to leave his home, the home where he had shared so many memories with his wife. The place he moved into is also called H.O.M.E., and is an organization seeking to help the elderly find not just a place to live, but a place where community can be built.

During our first meeting, I learned that he was sleeping most of the day, had no energy, was gaining quite a bit of weight, and only the oldest of his children came to see him occasionally. His life was in turmoil. At our next meeting, after doing a PHQ-9 questionnaire with him, I was not surprised to find him to be suffering from a “moderately severe” depression. He felt lonely, yet ironically, he did not want to spend time with the other residents. In his own words he needed “to get used to a new place, but it’s not the same as what I’m used to.” With that comment and others like it, it became apparent to me that A.R. depression stemmed from change and social isolation. His reticence to engage stemmed mostly out of his introverted nature. So, I set myself a couple goals: to encourage him to make the effort of coming to H.O.M.E.’s communal activities and to gradually challenge him to adopt a more active lifestyle.

Every time I met with A.R., I saw small improvements. Initially, he would just recline in bed during our meetings, but more recently he started getting dressed and sitting with me. Over the last six months, I have spent much of my time with him asking him about his life. At first, he was shy, but his openness has increased every time I see him. We have looked back over the things he is proud of (his long, happy marriage) or the things he wishes he had done differently (not dropped out of high school). As we have talked, I have seen the good it has done him to be able to share his experiences.

When I saw him about a month ago, he excitedly told me that he was walking up and down the steps, and that his family had come see him for his birthday and had taken him out to eat. He also wanted me to know that he was looking forward to the spring so he could get outside more. I am extremely glad that his depression resolved and that he is feeling at home again. I do not think I can take credit for the turn-around, at least not by myself. It has been a team effort, as I know A.R. has had nursing student counseling him on his eating, and a physical therapist working to lessen his back pain with moderate exercise. Also, over the course of the last six months, Arthur started participating in the activities at H.O.M.E.

When I visited the last time, I smiled to myself as I surveyed Arthur’s room: a new poster of Wrigley Field, new curtains, and a new easy chair in his room, and some pictures of his children.

S. Sean Salés

2012-2013 M2 Scholar

My elderly patient told me she needed a pelvic exam because she had a fungus that itched so badly it was driving her crazy. She had told me earlier that she had been to her primary care doctor the other day. So I asked if she had brought it up with him. She told me that she had, but he didn't give her referral to a gynecologist and she didn't know why. She said she would bring it up again at their next appointment, which was soon, but she had lost the paper with the date on it. She asked if I would call the office for her to ask when it was. When I called to check the appointment time, the doctor's office had already arranged an appointment at a gynecologist nearby as well as physical therapy for an injury she had had. I wrote down all her appointments, their times and locations for her on a piece of paper and taped it on her wall.

As I got to know her throughout the year, I realized she was having difficulty with her memory and was trying to hide it from me. She was also very isolated from the other elderly people in her living community and I wondered if it was because she was trying to hide it from them as well. Before her stroke, she had always been an independent woman who went on adventures and created. Afterwards, she had to give up the home she had built with her own two hands, which was filled with artwork and antiques she had repaired and move into a small room at the living center.

Through learning about her and trying to help her organize her healthcare, I learned about how difficult the adjustment was for her after her stroke, her fears of having another, her guilt about no longer being able to help her homeless son, and her hopes for rekindling her love of art in the future. Although her personal story is unique, many elderly patients share her obstacles. Social isolation, depression, losing memory, being unable to walk or drive to appointments, no longer earning income to pay for medications and housing are factors that can affect many of the elderly and their health. By learning about them firsthand, in the future I will be able to understand and be respectful of my elderly patients and their limitations and special concerns.

Caroline Holmes
2013-2014 M2 Scholar



As part of the geriatric's concentration during my second year in medical school, I was fascinated by the uniquely different set of skills required to work with this population and realized the importance of addressing mental health with this population. I did not, however, realize until after completing my SLP project as an M4 co-tutor in the geriatrics concentration, that mental health issues among the geriatrics population were for many patients, much more pervasive than chronic medical illness.

When my M4 partner and I visited each of our community sites, we had anticipated targeting cognitive issues among our population with our intervention. However, after doing our needs assessment at each site, it quickly became very clear that the majority of our clients were suffering from depression, anxiety, and other mental health issues, which had a direct impact on their physical health. The most prevalent mental issue identified among our population was depression, with co-morbid anxiety, which many of our clients alluded to during our cinematherapy sessions, as contributing to severe social withdrawal. When completing our literature review, we were also taken aback by the lack of mental health service for the geriatric population. Although having a suicide rate of 21% (the highest in all age groups), and an estimated 18-25% of this population suffering from depression, anxiety, psychosomatic disorders, adjustment to aging, and schizophrenia, this population consumes only 7% of inpatient psychiatry services, 6% of community mental health services, and 9% of all private psychiatric care. Given these startling statistics, it is vital that the cause of the lack of mental health services for the geriatric population be examined in order to determine whether it is due to the failure of physicians to address these issues with their geriatric clients, as a result of a low number of geriatric patients addressing these issues with their physician, or due to generational misconceptions among the geriatric population that taking advantage of mental healthcare carries with it a stigma.

Understanding the pervasiveness of mental health issues among our population and witnessing the negative impact of these issues on the physical health of our clients has definitely impacted the way I interact with geriatric patients. Rather than avoiding these issues with patients, I prefer to address them directly, and in doing so, describe mental health as a treatable issue. In addressing the patient directly, rather than their family members, I also give patients time to speak and I do my best to address any negative misconceptions of mental health problems from the start. While these practices may not engender immediate trust among new geriatric patients, fostering open communication and addressing mental health directly may allow patients to feel comfortable addressing mental health issues in future interactions.

Another issue encountered by my partner and I during the execution of our project, was the although these mental issues were pervasiveness among our clients at both the Nathalie Salmon House and the Pat Crowley House, the population at the Nathalie Salmon House was much more difficult to reach with our intervention. On our visits, many of the clients remained isolated to their individual living spaces, and rarely ventured out into community spaces for social interaction. In spite of numerous attempts to increase participation by changing the timing of our visits, we found the same outcome each time. This



social isolation among the residents at Nathalie Salmon House made it extremely difficult to complete our intervention, which was already proving successful with clients at Pat Crowley House. In speaking to resident administrators at Nathalie Salmon House, we learned that this social isolation was not limited to our intervention but seemed to be a pervasive issue at the site.

In speaking with our M2 colleagues, it also became clear that this social isolation was directly associated with the health problems experienced by clients at Nathalie Salmon House, including obesity, hypertension and diabetes. Our experiences at Nathalie Salmon House made us realize that a more intensive intervention was necessary for the clients there, and that establishing trust with the clients from the outset was vital to the survival of the intervention itself. In addition, our experiences reiterated to us that each client is different and has very different needs, which are often addressed by very different methods of intervention. We, therefore, recommend to future M4's, that needs assessments for clients at Nathalie Salmon House be individualized on a per-client basis, with the proposed intervention initiated by establishing trust among the clients.

As medical students, we often find it difficult to navigate the multiple medical problems experienced by our geriatric patients, and in doing so, fail to address the mental health issues that may accompany—or even worsen—these chronic medical problems. Given the startling statistics surrounding the utilization of mental health services among this population, it is vital that mental health issues be directly addressed with our elderly patients, with recognition that each patient is uniquely different; the proposed treatment must “fit” both the patient and their illness.

Carmen Flores

2012-2013 M4 Scholar

Movie Therapy and Reflections on Four Years of Learning

"That's life! He was depressed. We are all depressed."

A gloomy comment made by a H.O.M.E. resident after viewing the movie *About Schmidt*. My geriatrics concentration co-partner Carmen and I knew that depression, anxiety, and other mental health problems are rampant in the elderly population. We had done our research, and we knew that these problems are under recognized and undertreated in this group. For that reason, we wanted to address these issues above all others with our clients at Pat Crowley and Natalie Salmon House. To do so we chose the most engaging form of media we could think of - movies. We theorized that watching and discussing movies as a group, our "Movie Club Project", would serve as a means of observational learning for clients, a chance to reflect on their own emotions and problems through the metaphors of the characters, and a non-threatening environment to interact with their peers and learn from each other. We were ambitious but realistic. We hoped first to entice our clients to be present, second to entertain them, third to engage their active participation, and fourth to treat them. We expected some hesitance and resistance from the clients, but we thought we could win them over in the end, and we hoped we could help them, somehow, at least a little.

We had read in the literature that seniors are very willing to speak about death and dying, and likely other mental health issues, if addressed with them. Still, it was hard for me to think of discussing these topics with the clients. I believed they would be painful for them to consider and difficult to broach. Comments like the one quoted, free-flowing from the very first session, proved me wrong and the literature right. I was delightfully surprised by how candid and on-point our clients were in their reflections on the movies. When given the opportunity for open-ended discussion about the films, they immediately honed in on the weightiest and most poignant issues uncovered by the movie. One client commented, again after *About Schmidt*, "Anger and fear dominated his life. If he wouldn't have had those, he could have functioned better..." Not only did they recognize the root of the characters' problems, they were able to relate connections they found with their own lives and express the lessons they learned from them. On the film *Young @ Heart*, a documentary about a senior chorus group, one client said, "The movie made me think. I'll be 65 years old this year. It seems like I'm trying to give up, but I'm not." And in an uplifting tone, after viewing *The Bucket List*, one client commented, "We are here on this earth to learn to love each other." These conversations made me realize that it was not the clients who were reticent to talk about the difficult issues, but rather it was I. I had underestimated them and projected my own insecurity on them. Whether or not we had helped them to become more open and self-reflective, they had certainly helped me to do so.

It was evident from the sessions that we had achieved at least our first three goals, which was as much as we had hoped but even more than we had expected. We wanted to know then, at least subjectively, if we had succeeded in

our final and most important goal - to help our clients, to treat them. To find this out, we surveyed our clients on the last day. From their responses, we learned that the movie sessions had, in fact, had some positive impact on them. All participating clients enjoyed the "Movie Club Project" and desired it to continue. The majority reported being more interested in participating in group activities after being part of the movie group, and the majority also felt more comfortable speaking about their thoughts and opinions in a group setting. Nearly all clients stated they felt more aware of issues that affect the lives of people in their age group and were more aware of their own feelings regarding aging. I was thrilled with these results and even more thrilled when we learned that the clients liked it so much that the resident assistants at Pat Crowley House were going to continue the Club. It was extremely gratifying to see our vision and efforts have such a positive effect on the clients we cared about so much, and that there was a means for them to continue to do so.

Reflecting on my years in the program, I find myself incredibly grateful to have had the opportunity to participate in the Patient-centered Medicine (PCM) Scholars Program. My experiences over the past four years, and in the Geriatrics Concentration especially, have taught me much about myself and about people, about how I relate to people as patients and as human beings, about cultural competence and how to care for all patients with compassion, about the practice of medicine in this country and how to work within the system to deliver the appropriate care to patients, and about what it means to be a physician and my role as such in my local and global communities. These lessons are invaluable. I will take them with me as I very soon begin my residency training and carry them through my (hopefully) many years of practice.

Thank you.

Rachel Guild

2012-2013 M4 Scholar



Reflections on Geriatric Medicine

Age is opportunity no less,
Than youth itself, though in another dress,
And as the evening twilight fades away,
The sky is filled with stars, invisible by day.
~Henry Wadsworth Longfellow, *Morituri Salutamus*

In medicine there are many external pressures that push care providers to work quickly and efficiently – fifteen minutes per patient, triaging, and prioritizing. In stark contrast to this scenario, I had the unique opportunity this year to form a relationship with a geriatrics patient without the pressures of time. The point of this experience was to explore the unique concerns and goals of my patient and figure out how I could help him attain these goals.

After my initial meeting with T.S. where I took a full history, I went home and listed what I thought were his main health concerns under the assumption that we could work our way through this list over the upcoming year. However, unlike in a traditional outpatient setting where the physician prescribes medications and gives lectures on good health habits, I would meet with T.S. in his home for an hour. During these sessions I realized that T.S. was having a difficult time adjusting to his new surroundings in an assisted-living facility with new neighbors and routines. Before I could motivate him to exercise or eat healthy, he first needed to adjust to his living situation and form new friendships. From this experience, I realized that emotional well-being plays a significant role in a patients' physical health. As geriatricians we must take a holistic approach to medicine and work with our patients to understand where their priorities lie and how to best help them obtain their goals.

Aside from the health lessons I took away from this experience, I also am thankful and feel privileged to have formed a relationship with T.S. He shared with me stories about his life in Chicago, his experiences as a social worker, and advice on my future career in medicine. Too often our society disregards the elderly as fading members of our community who do not have anything to offer. Yet it is the elderly who have experienced life and have the most knowledge to share.

Laura Rodgers
2014-2015 M2 Scholar

A Year with “Charlotte”

I had the pleasure of spending this academic year in the Geriatrics Concentration, and I was paired with “C.L.” This sassy 74-year-old taught me a lot about what it takes to build rapport with a patient. It takes time and dedication, but that doesn’t mean it isn’t fun! I was able to get a sense of what “Charlotte” enjoyed doing outside of The Pat Crowley House, and it helped me to understand her health needs and priorities. Mobility is very important. My experience with “Charlotte” also showed me how difficult and confusing the healthcare system can be. It’s hard to know what is and isn’t covered, and the importance of a patient advocate or navigator was apparent to me. I’m thankful for my experience, and I plan on using what I’ve learned in my future as a physician.

Preiyaa Gopinath

2014-2015 M2 Scholar



Insight into Geriatrics and Dementia

This academic year, I worked with a geriatrics patient at H.O.M.E who suffers from early Alzheimer's Dementia. His long-term memory is preserved, but his short-term memory is mildly impaired. He has difficulty remembering if he took his pills a certain day, shutting off the water after he uses it, and trouble recalling things he did the other day. He is on seven medications and has trouble remembering to take his inhaler in addition to his pills because it is a different type of medication and requires different set of skills to use. He has asthma and would complain of coughing a lot since being at H.O.M.E due to not being able to remember to take his inhaler.

In meeting with him in the fall of 2014, I learned that he just moved to H.O.M.E in the spring of 2014, prior to being in a nursing home for about a year. Due to his dementia he needed assistance living, especially since he has no family in area. He received the medications and care that he needed, but due to the restrictive nature of the nursing home, he became severely depressed and his mobility declined to the point where he needed a walker. Since being able to transition to H.O.M.E, he has gained a lot more freedom and his depression improved along with his mobility where he no longer needed a walker. He is very active when the weather is warm because he is able to go out and walk around the block for exercise and take the bus to visit his friends in the area. I had very limited knowledge of nursing home care when starting the PCM program, so I was able to learn a lot firsthand from my patient about his experiences there. I was shocked at how restricted and unhappy he defined his experience at the nursing home, especially since this was a well-respected nursing home in the community and just how much a difference having a little bit of independence can impact your health in a positive way.

In practicing patient-centered medicine, I set goals with my patient based on his specific situation that would be beneficial to him throughout the year and help him adjust to his new home. We worked on exercising more indoors during winter and using the indoor treadmill to walk, since he was not going to be going outside as much in the cold weather. He also reported stiffness in his shoulders, so I wanted to incorporate flexibility exercises into his exercise routine recommended by the American Geriatrics Association. He had trouble remembering to incorporate these flexibility exercises so we decided on hanging a printed handout on his bedroom door to remind him to do the exercises when he could. It also had drawings to show him steps to do the exercises when I couldn't be there to do them with him. I made a reminder note to put on his pillbox cover to take his inhaler to hopefully help improve his asthma symptoms. And I encouraged him to socialize more with the residents as he was new and did not know anyone. I felt it was important for him to socialize, especially to aid in preventing depression, which is common in the elderly.

Over the year and up to my final visit with him in the spring of 2015, I noticed his flexibility improved, which I think was contributed to the exercise handout that helped him remember. He didn't use the indoor workout room as much to walk on the treadmill, but as long as he was walking through the house and doing

stretching exercises that definitely helped him vs. not being active at all. His cough improved as well as he wasn't complaining of frequent coughing as much. He also was talking more with residents. He didn't know everyone by name but recognized housemates by face and would socialize at group outings that H.O.M.E would participate in. I also learned that he had set up movie nights with some residents where he would play one of his movies from his vast collection for the residents to watch.

Working with my continuity patient emphasized to me the importance of patient centered medicine and that memory loss is an additional challenge to geriatric healthcare. This was my first experience working with a cognitive impaired patient and it taught me you have to be patient with them and recognize their additional barriers in healthcare. With these patients, when assessing ADL and IADLs, it may not be an issue of not being physically able to do a task but rather not being able to do it because of mental impairment. For example, my patient can recite to me the steps needed to drive a car, but mentally cannot do it because he would not know where he would be driving and may not remember stopping at a red light, etc.

It is also important to be aware of additional barriers these patients face such as remembering to take medications, remembering when to go to doctor appointments, not understanding medical conditions therefore not being compliant with certain treatment options, and remembering the route of transportation needed to take to get to the doctor appointments. Another important thing I learned was the effectiveness in simplicity with medications for these patients. Before working with my patient, I didn't understand how it could be difficult to take medications twice a day. But for my patient, taking pills once a day was an issue, especially if they were a different type (liquid vs. pill vs. inhaler). Working with my continuity patient showed me firsthand some of the barriers geriatrics patients' face that I never thought about before. Because of the PCM program, I am more aware of these issues and how to address them when they come up as well as the additional challenges that mental impaired patients face.

Lindsay Boven
2014-2015 M2 Scholar

When I Met Her

When I met her for the first time, she mumbled. She was the representative we had found from the whole place to talk to us, four budding medical professionals descending on her home in search of an education. Our liaison introduced her as the matriarch, but it didn't seem she wanted the title. More than anything it seemed she hoped that whatever she said to us would satisfy us and would leave her to her morning coffee.

When I met her a second time, she assuaged my nerves. The last time had left me wondering if she really wanted to speak to a student, but it seemed a conversation was more manageable than the 5-person interrogation she had faced last time. She told me about the anxiety and depression she faced. Our liaison was surprised she had opened up to me like that, and I was grateful.

When I met her a third time, she staked out her independence. Her family, she said, was bothering her about quitting smoking. She would quit when she decided to, she informed me, and she just didn't want to yet. She even noted that maybe she'd want to quit if they hadn't pushed her so much. It was not the smoking that was at stake, but the independence she worked hard to keep.

When I met her a fourth time, she had news. She had fallen over the winter holidays and gone to the emergency room. Fortunately, she had no serious trauma, but the visit had presented her with newfound confusion about whether or not she had a new diabetes diagnosis. We cleared that up and touched back on the smoking – maybe it was her fall that made her change her mind. She was ready to cut back on her habit now. We made a plan.

When I met her a fifth time, she put away her cigarette. I had found her just as she was about to light up what she said was her second – and the last, she assured me – for the day. Her plan had worked, she said, she was down to two per day. Aware as ever of her own desires, she informed me she wasn't ready to cut down more just yet, but that she would be soon. I trusted her on that.

When I met her a sixth time, she smiled with me. She told me that sometimes people need time to make changes in their lives and that more healthcare professionals need to know that. Quitting smoking, she said, felt like her process, and though I had brought it up several times over our meetings, she was always in control. It also felt like her process to me, and while I saw that feeling independent may be even more precious as we age, the balance of control and motivation we created felt useful for patients of any age. Before I left, she said to me that she would tell her family about me, and I was so glad we had met.

Emily Graber
2014-2015 M2 Scholar

A Reflection on Our Older Population

When I first saw my client, I had the idea that I had to make absolute changes to make a difference in her life. This years' experience helped me recognize the true value of a patient- doctor relationship, something that may not at first seem as a priority compared to providing medical care.

My client and I formed a partnership to find an affordable medication for one of her ailments. However, we were not able to accomplish our goal. As soon as we got one step closer to goal, there would be another obstacle we had to overcome. Some of these include: limited options in picking a physician she felt was right for her; finding medications that would not produce side effects; and avoiding interactions with other medications. Making the important decision of picking an insurance plan that would provide the most coverage that she could afford also delayed the process. This experience made me more cognizant that there are many factors that have a significant impact on patient attendance and compliance.

As life expectancy increases, there will be more medical necessities that are not currently available. Medicare doesn't reimburse many medications or custodial help for older adults. It is important that as physicians we make sure older adults have the knowledge about what to do with changes in medications, know symptom relief strategies and have a support system.

One piece of advice that my patient wanted me to share relates to her previous line of work with medical malpractice attorneys. She found that more often than not, medical malpractice lawsuits were filed because there was a problem with communication. Patients had unrealistic expectations about their treatment. Many times this was because their physician failed to ask if their patient had any questions about their illness or treatment. As a physician, asking older patients about their experience living with chronic illnesses is something very important to me. To fulfill our role as caretakers we have to assure our older population has primary social, financial, and physical support, in order to provide the best care possible and improve their quality of life.

Jasmine Partida
2015-2016 M2 Scholar

80 Years of Music

I entered the room just like any other room of any other patient I've done during my short time as a medical student. I knocked three times and I waited for an invitation in. I didn't hear anything, so I decided to knock three more times just to make sure that I was loud enough the first time. Still, nothing. I knew there was a patient in there, so I just decided to announce that I was entering and go in. Sitting right next to the physician's desk, I saw a frail but bundled up woman clapping onto her walker. She didn't acknowledge that I entered the room, so for a second I thought she might have forgot her glasses at home, or that her vision may have been deteriorating. As I sat down at the physician's desk to pull up her chart, she finally noticed that I was in the room and was startled. She told me I was very sneaky, but I was very loud during the whole process. This started to clue me in to what might be going on.

Over the past month, she had started to progressively lose her hearing to the point where she couldn't even hear her favorite music anymore. I fumbled around trying to figure out how I could conduct this interview without shamelessly reporting back to the physician that I was in able to, because she was hard of hearing. I first tried using the old fashion pen and paper method, but I soon found out that her unsteady hands made it very difficult to have a two way conversation. I then took a moment and paused, and thought to myself, «how on earth can I ask her what what's wrong when I can't even talk to her.» I decided to try something new.

I pulled out my phone, went into the messaging app, and opened the speak to text feature. I spoke in my question that I want to ask her, quadrupled the font so she would be able to see it, and showed it to her. She laughed. She looked at me with a smile and told me, "well this is new." She continued and replied to my question. We did this back-and-forth for about 30 minutes until I could understand her story very well. It was very odd that in that moment there was a bridging of generations, most ironically through the very thing that separates them. Technology. During that short 30 minute time span, I realized that we must always adjust to the needs of our patients. Whether they are unable to hear, unable to speak, I don't have a home to go to after the doctor's appointment.

The patient seemed extremely distraught, and understandably so. She had gone on the first 80 years of her life able to hear, and now, within the course of a month that was gone. I believe that it is very important to be able to appreciate as a physician, that you are not just simply treating a set of symptoms, but instead, a human being. A human being with 80 years of beautiful memories. With ears that have hear first breaths taken and last ones left. Ears that have endured 80 years of music. Ears that have sympathized and have listened to thousands of conversations. It is important to understand that this patient hasn't just lost her hearing, but also many of the experiences that she had shared with them.

Faisal Akram

2016-2017 M2 Scholar

Don't Take Away My Chips!

Mrs. M sits quietly in her wheelchair,
Her breathing slow, but steady.
A small pin holds back her neatly combed hair,
Hands folded in her lap, patiently waiting, ready.

"My legs are a little swollen," she says.
3+ pitting edema noted on exam.
"She also has been short of breath,"
Her niece, the primary caregiver chimes in.

"Let us adjust her medications,"
The attending aptly suggests.
"And consider further restricting her salt intake,"
This is when Mrs. M gets distressed.

"Doc, do you know how old I'll be?
I'm turning 99 next week.
If I don't get my daily chips,
I don't know how I'll live, I might as well call it quits."

Mrs. M had lived a long, full life.
Her mind still sharp, her will strong.
However, eating chips was one of her greatest joys,
"Taking them away from me would just be wrong."

Geriatrics care opened my eyes to the fact,
That each patient population has its own unique features.
We shifted focus to maintaining her quality of life,
Understanding that the elderly can be some of life's best teachers.

Mrs. M is turning 99 next week,
We wanted her to enjoy her life, to live.
And so, the attending smiled and said,
"Go ahead, let her have her daily chips!"

Jennifer Chang
2016-2017 M2 Scholar

A Tranquil Ending

The first thing I notice when we pull up to the house is the park across the street. We had passed huge, blackened, broken factories on the way here, so the tranquil green space attracts my attention.

"This patient is amazing. So is her husband—they are both amazing," my preceptor tells me. We are here to visit a patient on hospice, a patient who had not been expected to live past the New Year. It's now late March, and daffodils are blooming in the front garden.

We walk up to the door and my preceptor rings all three doorbells ("I can never remember which one it is!"). A smiling middle-aged woman comes to the door and invites us inside: she's the 24-hour home help that this couple has been lucky to afford on their pensions. She ushers us up the stairs and into the flat, where we meet the patient's husband. He is in bright spirits.

"I was just about to go to the park when you rang the bell! I forgot you were coming today." My preceptor tells me that this man walks several miles every day in the park. He's in his mid-80s, but he shows no signs of slowing down. The man asks me several times if I speak Spanish—"Surely you are Mexican, no?" I smile and shake my head, telling him no, unfortunately I don't speak any Spanish.

He's brought us into the front sitting room of the flat, past a white sheet stretched across the doorway to enclose the patient's improvised room. It feels like a sanctuary here. There are pictures and statues of saints on the walls and in glass cases, as well as portraits of the husband and wife when they were young. Everything is clean and well kept, with stacks of diapers stored discreetly in the corner and a second bed positioned along the wall. I wonder if her husband sleeps here with her. It is so peaceful. The wife's hospital bed is positioned directly in front of the large picture window: she's looking out over the park.

We move to her bedside and introduce ourselves. She looks up at us and returns the pressure when we gently squeeze her hands. When I tell her I am going to take her blood pressure, she offers me her arm. She acknowledges and responds to each of my preceptor's questions, often directing her responses to her husband in Spanish. At one point he tells us, "She wants to know when she can go home. She sees you and thinks she is in the hospital." We reassure her she's not at the hospital. Her husband says that she does not always know where she is, but that they sit her up and show her the park to remind her she's at home.

When she was discharged home on hospice in late December, she could not speak. She had no sense of orientation and could not move her arms. Now she tracks people with her eyes, responds to commands, and has regained use of her arms and hands. Her husband tells us that her brother and his family came to visit from Mexico late last night—she recognized every one of them and even

asked about the family farm. She seems to be moving farther away from death, not closer to it.

My preceptor finishes up his exam, making sure she is being rotated to prevent bed sores, checking on swelling in her immobile legs, and noting the contents of her catheter bag. Everything about her person is clean, well-ordered, and precisely arranged. She is cared for lovingly.

She expresses some discomfort when my preceptor listens to her abdomen, so he inquired about how often she's receiving morphine. This is one of the few moments that I remember she is terminally ill.

We get ready to leave, and her husband reassures her one more time that she is at home and not in the hospital. He smiles that she could be so forgetful; he's delighted that she's still here. He's going to go out and take his walk in the park after we leave.

As we're driving away, I can't help but think of what could have been. She could have stayed in the hospital in December, away from her husband, away from her home, tended as best as nursing schedules would allow. Her husband would have had to commute to see her every day. Would he have been able to keep taking his walks in the park? Would she ever have spoken again? Would her family have made it in time to see her? Would she have lived past the New Year? Thinking of the profound peace of that room, of her surrounded by the people and things that mattered to her, of her looking out over the budding trees and winding paths of the park, I am so grateful for this gift of a tranquil ending. It is an affirmation for me that restoring someone's dignity and providing them with comfort and peace are as important as diagnosing and treating their illnesses. Practicing medicine is the art of improving life—which sometimes means knowing when to let go.

Christina Du Breuil
2016-2017 M2 Scholar

PCM Voices Short Story

I was really reluctant to enter the Geriatrics Track of the Service Learning Program. I've never had any experience with older relatives and spent the majority of my life volunteering in children's programs and shadowing pediatricians--admittedly, I was limiting myself a bit in this regard, but I have always had a passion for that particular patient population. Much to my surprise, I greatly enjoyed the Geriatric program.

One of my favorite encounters with a Mr. M. Immediately upon entering the room with my preceptor, Mr. M lit up. It was clear that he did not get a lot of company, so he really enjoyed having us there. It was really nice to just chat with him a little bit while taking vitals and hearing a little bit of his story. Mr. M asked me to write a text to his daughter because he couldn't see the keys on his phone, and then he asked us to help him read the writing on his prescription bottles. It turned out that he had misplaced his magnifying glass, and without it he was virtually incapable of reading. After 5-10 minutes of searching through his room, I found his magnifying glass and he was ecstatic. The reason this was so cool was that I didn't need to give him any meds or provide any medical care, just a basic task that drastically improved his quality of life.

Zachary Schoppen
2016-2017 M2 Scholar



Returning Home

The aging of the U.S. population has revealed multifaceted disparities seen in this demographic group. Gaps in healthcare, transportation, housing, and social inclusion need to be addressed to help older adults age successfully. My experience with the Patient-centered Medicine Scholars Program's geriatrics concentration offered a glimpse into the daily realities of older patients in my own community. Furthermore, it hinted that part of the solution may already exist.

When I was invited to participate in UI Health's physician home visits program for geriatrics patients, it seemed like a quaint throwback to a bygone era. It was a stark contrast to the increased focus on physician efficiency I had witnessed as a medical student, where I observed patients with complex medical issues being squeezed into short time slots. How could an old idea that appeared so incongruent with the current challenges in healthcare work?

During one of my first visits, I was warned beforehand that the patient's physical disability was both disfiguring and had left her bedbound. Prior to the home visits program, she was constantly in the hospital for preventable complications. Her chronic conditions were exacerbated by the fact that leaving her home for any reason, including healthcare visits, was both complicated and stressful for her. The program allowed her to receive regular healthcare within the confines of her own home.

When I looked around her room for the first time, the reality of her situation sunk in. There were signs of her daily struggles in every nook and cranny. The toilet, television, bed, makeshift kitchen, oxygen tank, and miscellaneous medical supplies overwhelmed her small bedroom. Yet, her room was also filled with proof of a completely different life not so long ago. Artwork, made with the bold strokes of a child, could be found on one wall. Photographs, of the patient as a formerly independent woman, could be found in another corner. The undeniable contrast of her medical necessities and personal effects was striking. It exposed the truth of her entire life being restricted to 300 square feet.

The physician home visits at UI Health are a lifeline, for that patient and many other elderly homebound patients, who cannot be served by the traditional healthcare model. These visits also benefit the physicians. They facilitate additional opportunities to understand patients' daily environment and struggles outside of a hospital or clinic setting.

The vulnerabilities and physical limitations of the aging population are challenging the way healthcare is currently provided. My experience with the geriatrics home visits has shown me that new technologies or advancement in medical knowledge are not by themselves enough. Part of the solution may involve applying lessons from the past where patients were treated wherever necessary, even outside of our usually efficient hospitals and clinics.

Pyone David

2016-2017 M2 Scholar

164 Geriatrics 

As Friend or Foe

The right to die on your own terms
Is something we have lost.
Getting old is not disease,
But we treat it as such.

Treating symptoms, hiding sick.
Ignoring the inevitable.
Pills and procedures maintain our "health",
But health is more than physical.

A physician's task and job is not
To ensure prolonged survival,
But to enable well-being of the person,
Whatever that may mean.

Enter then a practice new
Treating age, improving lives.
Doing that which we most fear
Addressing the finish line.

Getting old is not disease,
And death is not an option.
We will go the wrong way if
We live in dark too long.

Until our training teaches us
The truth of end of life
All will die in hospitals
Which of us so few want.

Afraid of death, most of us
Will not discuss the end
So it falls on geri clinics
To navigate the art.

Delicate yet forceful,
They make clear the end
Is not an option.
An inevitability that can be greeted

As friend or foe.

Joshua Smith
2016-2017 M2 Scholar



HIV/AIDS

My Eye Opening Experience with HIV

I chose the HIV concentration because after having learned extensively about every detail you can imagine about the virus, I realized we never really learned the story from the patient's perspective. We all know how prevalent HIV is in the United States and we've been engrained throughout grade school to be precautious in any sort of sexual activity. But what if just one time we make a mistake or become accidentally exposed to HIV?

One thing that became apparent to me from this concentration is that because of advances in HIV treatment, it is not readily apparent who has it. The person sitting next to you right now may even be infected and you would have no idea. In fact, 25% of HIV cases are undiagnosed and those 25% are the ones who are the most infective. Even though HIV is disproportionally prevalent among African Americans, it does not make every other race immune to the disease. HIV does not discriminate.

However, there is a certain stigma against HIV that has been hard to eliminate. In 1982, AIDS was actually first coined as "Gay-Related-Immune Deficiency". That misconception itself may be changing with time but it is still there. One of the patients we saw said that his mother used to bleach every dish he touched because she thought he would infect everyone. This kind of misconception leads to the idea of HIV patients needing to be quarantined. This sort of stigma is exactly why many patients are hesitant in disclosing their status when what they really need is support.

Another valuable lesson I learned was on the issue of medication compliance. As a medical student, it is easy to say to a patient "Take your medicine every day for the rest of your life" but we do not realize that it is easier said than done! Hearing firsthand from my patient was an eye opener into how bad the side effects of the medicine were. He was diagnosed in 1989. Back then AZT was the only medication available and had a horrible side effect profile when taken alone. For that reason alone, he stopped taking AZT for 10 years until he got so sick that he was on the brink of death in the ICU. His near death experience was the only thing that pushed him to start taking his meds regularly. My patient's story with medication compliance is not unique.

Another common issue is that many mothers may decide not to take their medicine because they want to focus on raising their children and only start taking their medicine when they are pregnant. As soon as they deliver, the mother will stop taking her medication again. Luckily the mother-to-child HIV transmission rate is less than 1%.

Overall, my experience with the HIV concentration was amazing. It really made me change my perspective on HIV. I feel that I have come out of this with a broader understanding of what HIV patients suffer through and I can use this experience to become a better physician in the future.

Syed Mustafa Alavi
2012-2013 M2 Scholar

"I see that something vital appears to be vanishing. It seems to me that medicine has indulged in a Faustian bargain. A three-thousand-year tradition, which bonded doctor and patient in a special affinity of trust, is being traded for a new type of relationship. Healing is being replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technological procedures" (Lown, 1999). It was reading statements like this in college that made me decide that when I entered medical school I would always try and hold on to the art of medicine. I am very fortunate for being in a school that has a program called Patient-centered Medicine (PCM) Scholars Program. Being part of PCM as an M1 taught me to create a relationship with a specific patient and finishing PCM as an M2 has taught me to create a relationship with a patient population. There are many reasons why I chose the HIV/AIDS concentration, but at the forefront were the words of Dr. Ruth Berggren, "HIV/AIDS patients are the most marginalized."

From the visits to Edge Alliance I learned that there are many necessities that take priority over compliance for a patient who is suffering from a chronic illness. The patient needs a safe home and community before he or she can adhere to any medical regimen needed to get better. It now seems so obvious, but it was a message I failed to get from learning about compliance in the classroom.

In order to be a good physician, I must not only create a loving and caring relationship with my patients, I must also be able to understand and engage the community in which my patients live. I still have so much to learn about being a good physician, but thanks to programs like PCM that have really transformed my patient experience, I know that I am on the right track.

Lilian Gonzalez
2012-2013 M2 Scholar

Citation:

Lown, B. (1999). The lost art of healing. Ballantine Books.



Original Sin

"I was born into it." The words came out of his mouth matter-of-fact. An innocent baby born into this world with HIV. There was nothing he could have done to prevent it. Nothing he could have done to change his fate. It wasn't fair. Doomed from the start.

Despite my initial shock and devastation, I surprisingly came to see that this patient, now 28, was very optimistic about his situation. He didn't blame his mother, and he didn't feel bad for himself. He had accepted his fate and was doing the best that he could to live with HIV. As he said, the early days of HIV were like a death sentence; however, today, the disease is manageable. For that, he was grateful. At first, I had questioned how anyone born into this situation could ever be grateful. However, this patient had been able to find a silver lining where there, seemingly, could never be one found.

I was grateful that he had shared his story with us. Grateful that hope could still be found in such a devastating situation. I was grateful that he had broadened my perspective on the types of patients that are infected with HIV.

Katie Kinzer

2012-2013 M2 Scholar



"It's fine to celebrate success, but it is more important to heed the lessons of failure" –Bill Gates

My experience this year in the Patient-centered Medicine (PCM) Scholars Program went something like this:

Summer 2012: I'm accepted into the PCM program and assigned to the HIV concentration! I'm feeling really excited and full of purpose, anticipating all the things I'm going to learn from patients, and the relationship I'm going to develop with one patient in particular. I'm so happy to have the unique opportunity to enter a new world and to directly affect someone's life.

Mid-September 2012: First visit to Edge Alliance, during which we meet several patients and listen to their stories. Feeling really nervous and aware of a gulf that exists between me and the patients, even though I don't want it to. I'm a healthy, white, middle-class woman worrying about getting good grades; our patients are HIV-positive, black, impoverished citizens worrying about how to survive. I'm eager to hear about their lives, their daily struggles, their perceptions of healthcare workers, and their goals and dreams. I'm hoping to narrow the gap between us, even if only a little.

Late-September 2012: I contact my assigned patient to set up a one-on-one meeting with her, so I can learn from her and accompany her to her doctor's visits. We agree to meet in early October. I'm really nervous because I'm shy when meeting new people, but I'm also excited to get the ball rolling.

Early October 2012: I arrive at Edge Alliance to meet my patient for the first time. I call her on the phone so she can let me in the building. It turns out that she is not home and is not planning on meeting with me that day because she is busy. I am disappointed and mildly annoyed, but I ask her if we can reschedule. She says that's fine. I've had a setback, but I'm still excited about the program and meeting my patient, and I completely understand that we can't always keep our commitments.

Late October 202: I call my patient to reschedule. She tells me that she no longer wants to be a part of the program because she's too busy. I tell her I understand and thank her for telling me. We hang up. I feel disappointed again, not by my patient but by the situation. Later in the year, I will wonder if I should have encouraged my patient to stick with the program, or if it was the right thing to not question her decision.

Early November 2012: I'm assigned a new patient. I'm excited because I remember her from our first visit to Edge Alliance, where she was bubbly and talkative. I look forward to having an enriching experience with her. We agree to meet mid-month at our group's next visit to Edge Alliance.

Mid November 2012: We M2's go to Edge Alliance with prepared presentations on topics our patients wished to know more about. My group's presentation is about Nutrition and HIV Medication Side Effects. The presentation goes well,



but my patient isn't in attendance. After my experience with my previous patient, I'm not surprised, but I'm feeling a little frustrated, especially because my new patient said she would definitely be there. I begin to feel discouraged, but I'm still confident that everything will work out.

December 2012: Finals are coming up, and so is Christmas. I'm really stressed out about school and have a lot of family responsibility, and I can't imagine putting anything more on my plate. I postpone calling my patient until after winter break, something I feel really guilty about.

February 2012: I call my patient, but someone else answers her phone, saying she's not home. I explain who I am and ask when I can call back.

Early March 2012: I've called my patient a couple of times now, but it's never her who answers the phone, and she's never available when I call. I feel frustrated because I know I have a great patient to work with, but getting a hold of her is so difficult, and time is running out.

Mid-March 2012: I finally get a hold of my patient! I remind her who I am, ask her if she has any doctor's visits coming up, and whether or not she would be willing to let me tag along with her. She tells me she has one coming up on the 28th and that she's fine with having me come along! I'm happy. I tell her I'll call the following week to confirm the appointment time and location.

March 26th, 2012: I call my patient to confirm her appointment and that I can accompany her to it. She tells me that she doesn't have any appointments until July. I thank her and we hang up. I feel defeated. I haven't been able to accomplish anything with my patients this year. I have failed.

April 1st, 2012: I'm trying to write a reflection about my PCM experience. I'm not sure what to say about it; mostly I feel frustrated. But through the frustration, I've discovered something: for a patient with HIV, it is probably not a priority to help a med student learn. It is not a priority—when you finally have enough energy to attend an event at your child's school—to make it to a scheduled meeting. It is not a priority—when you're in bed, too tired to get up and too sick to eat—to attend a presentation on medication side effects. It is not a priority—when you are finally able to get a roof over your head—to take a phone call from a pestering med student. There is nothing wrong with this; in fact, it makes a whole lot of sense.

Through my frustrating failure to connect with a patient this past year, this is the simple, powerful lesson I learned: that my priorities and my patients' priorities are not one and the same.

My year in PCM didn't turn out the way I expected, but I am grateful to have been a part of the program. I do not live the life of the patients I met at Edge Alliance, and I do not pretend to fully comprehend their experiences. But I do believe I have gained an understanding of some of the challenges they face on a daily basis, and I believe that this has helped me to become a more



compassionate person and future practitioner. It has helped me learn firsthand that medicine doesn't work if the patient's priorities are not taken into account. It has helped me understand that "non-compliance" is a very non-descript, pejorative and largely inaccurate term. Mostly, it has helped me to have an attitude and thought-process that is more patient-centered.

Which—when I think about it—was basically the main goal of being in this program in the first place.

Jenifer Lloyd

2012-2013 M2 Scholar

HIV/AIDS



Seeing the Person

One of the challenges a medical student faces is seeing a patient as a person, not just their symptoms, disease, medical history, and medications. In some respects, it is perhaps easier for us since we do not yet carry the daily reality of living and working as physicians. Everything is still new and shiny, a novel experience. But we often make the mistake of thinking that medical school is just for learning medicine when it actually requires contemplating the vast complexity of the human condition in order to consider the role that health and disease play within it. Perhaps it is because many of us are still tenuously developing our own nascent identities and naïve in our worldly exposure but connecting with a patient with whom we feel we have absolutely nothing in common is daunting, uncomfortable, and difficult. So it is tempting to not try at all. That's kind of cowardly, isn't it?

When I am an experienced clinician, there will likely be situations that necessitate strategic detachment, and I hope to be able to discern them. But right now, while I am learning the basic framework of disease and treatment, I also need to be learning how to holistically assess a patient and his or her needs. The framework is of very little use unless it is applied and individualized. It cannot be mistaken as the person herself or himself.

Tiffany Lu

2012-2013 M2 Scholar



I was introduced to AIDS at a very early age. My aunt's best friend was diagnosed and quickly placed in a hospice like facility to live out the rest of her days. Since that time, I have watched the evolution of this disease from a death sentence to a somewhat manageable illness. My continuity patient and the many patients I met at the Edge Alliance proved there is life and laughter after diagnosis.

The poem below is dedicated to Marion who sparked this journey is truly a survivor.



Positive

Yes, life is starting to look up for me
Kids, my husband, my own family
The drug use, that was the old me
An annual checkup, cool breeze
Then the doctor softly said three letters: H I V
Who would have thought that three letters when strung together could take the
wind out of me?
Now I'm told that they need to test everyone that has had contact with me
Does that include my friends, my foes, my family?
Now I'm stuck in this dark haze maneuvering through a maze of my own
confusion
So I had to educate me before I bared the individual Scarlett letter for the world
to see
The new age of Leprosy
I thank God for a family that was able to see me beyond the cloud of my disease
Now when people come through the Core Center, they see me
A vision of an overcomer, who continues to work in advocacy
No, it's not easy; life adjusted not interrupted
Society may place labels: woman, black, poor and now status positive
All of those just tell a piece of the story
I choose to focus on the high of the mountain not the Valley of HIV
Just call me a SURVIVOR.....now that is a name that encompasses me

Tenisha McCaskill
2012-2013 M2 Scholar



Determination

Determination. This is the one word my patient taught me this year. That, in life, you will be faced with multiple bouts of adversity. Some may have been precipitated by your own actions, but others may just happen. Acceptance is the hardest part. For my patient, accepting she had HIV was half the battle. In the beginning there is denial. There is a sense that you just don't care. Why is my life worth living anyways when you see no light at the end of the tunnel? When you are addicted to crack cocaine, when your next high is the most important priority, wouldn't it just be better if I waste away? Your doctor just comes in and tells you that you have HIV and then puts you on a bunch of meds that you don't even understand. You just become frustrated.

She taught me though that you have to pick yourself up from the down times. You have to take control of your demons. You have to find a purpose in your life; and for her, she realized that her children needed her. They needed a competent mother. So she set her mind to become a competent mother and like she said, 'if I set my mind to something, I know I'm gonna get it done'.

She is determined to live with HIV, but not be defined by HIV anymore. In many ways my patient defines the daily struggle of many patients we will meet in our practice as future physicians. We will meet patients who are still struggling with how a medical diagnosis may be life changing; who are lost as to how to proceed with the diagnosis. Many times the way to guide our patients is to give them the time to tell their story, to let them have a voice so we can better understand how to meet their needs and allow them to feel cared for. If we practice as patient-centered physicians, we will hopefully find ways to guide our patients to live life with their illness rather than have the illness define their life, because, as my patient taught me, every person has determination. Sometimes it just takes time to light that fire.

Christine Wang
2012-2013 M2 Scholar



Is a Diagnosis of HIV Really a Death Sentence?

What will you do if you were given the diagnosis of an incurable disease? Will you take a loan and travel around the world knowing that when it comes time to repay the money, you won't be around or will you make the best out of a terrible situation so that when the final buzzer sounds you will go with no regrets.

This academic year, I had an opportunity to work with an incredible woman who has completely changed my view as far as HIV care and management is concern. Before working with HIV patients this year, I had the mentality that for an HIV patient to live a fulfilled life, he or she needs to eat right and stick to his or her therapeutic regimen; but I was wrong. After working with Miss T for this past year, I have come to realize that the cognitive attitude and emotional stability of a patient can go a long way to influence the therapeutic outcome.

Miss T was diagnosed with HIV in 2001 and the first thing that ran through her mind was "death from above". It took a while for her to wrap her head around this incurable disease. Before she was diagnosed, she was living her life without a care in the world. She knew that HIV existed, but she never thought for a second that she could get infected because she was consumed by her world of drug addiction. Her HIV diagnosis made her re-examine her life. She decided to get clean, loss weight, quit smoking, eat healthy, and go back to college to earn a degree. She told me that she has been healthier than she was before her diagnosis and her secret has been not letting HIV define her life.

As future physicians, how do we want to shape the future of medicine? Do we just want to concentrate on the therapeutic aspect of medicine, or do we want to build on the already laid foundation of the holistic approach? After all the experiences that I have had this year with the Patient-centered Medicine (PCM) Scholars Program, I definitely know the type of physician I would like to be. What about you?

Roland T. Njei

2013-2014 M2 Scholar

Expectations

In the midst of trying to squeeze every bit of information our books and lectures tell us about medicine, it is nice to get a glimpse of what all our hard work is working towards. Through the Patient-centered Medicine (PCM) Scholars Program, not only have I had the real life clinical experiences we all, as students, get excited about, but I have also seen the realities that we would all like to ignore.

I had the pleasure of working with residents of HIV patient housing program in Lawndale as part of the HIV/AIDS concentration of the Service Learning Program. Overall, it was a great experience, but it also left me feeling discouraged. As a part of the program, I was to be paired with a resident to discuss their experiences, barriers, and concerns for their healthcare as individuals with HIV/AIDS. After being given one resident's contact information, I excitedly dialed their number in the hopes of getting inspiring insight into their lives, only to have the phone ring through to voice mail. So I left a message with information on all means of getting in touch with me. I waited for days with no reply. I tried calling again, with no answer. This continued for a couple of weeks until I was assigned a new resident who was willing to work with me. Unfortunately, the result was the same. It was not until I joined a faculty member in his HIV clinic that I actually got to interact one-on-one with a patient.

While my conversation with the patient at the clinic was rewarding, to say the least, the experiences I had with the residents at the housing program made me question aspects of healthcare that I had not fully considered. We are taught, from the beginning, to include patients in every decision we will make as future doctors because healthcare should be approached as a collaborative effort between physician and patient. I had always recognized the shortcomings of physicians when they did not allow this cooperation to happen, but I had never considered it from the patient's side.

Here was the student, ready, willing, and available to talk to a patient, wanting deeply to understand their struggles with their diagnosis and how it affects both their daily lives and how they navigate the healthcare system, and yet, not one would return a phone call. I am not criticizing any of the residents for never responding, but it discouraged me to know that for whatever reason, whether it was lack of availability, desire, or something else, there were enough barriers to impede on this interaction.

This year with PCM has opened my eyes to healthcare beyond medicine. The system works and the system fails, but no matter what, I have learned to keep my good intentions as an aspiring physician, collaborate with patients, and work to make healthcare just a little bit better.

Alexandra Roybal
2013-2014 M2 Scholar



It Only Took Five Minutes.

I sat down with G.R. to get to know him as part of my project to work with an HIV+ patient for the year. The time was to be spent getting to know him and his story. My goal was just to get a little bit of background so that we could feel more comfortable with each other in future visits.

All I asked him was how he felt when he heard he was HIV positive, and G.R. told me his whole story. He told me how he had no idea he had contracted it, how he screamed and cried when he found out, and how he was too scared to tell his mom. He told me how he was able to cope with it all, how it affected his day-to-day life, and how it affected his relationships. He brought up the man that he knows gave him HIV. He looked me in the eye and said, "If I ever see that man again, I am going to kill him." And when he looked at me like that, I knew that he was absolutely serious.

I asked G.R. what advice he would have for any future doctors working with HIV positive patients. He told me to make those patients feel like they are somebody.

I left our encounter thinking about the advice that G.R. gave me. I don't want my future patients to feel like they are just a case. I want them to feel like a person who happens to have an unfortunate illness. In the time I spent with G.R., I learned who he was by hearing about the difficult road he has traveled. I felt his fear, helplessness, and especially his anger about contracting this infection. And ultimately, I know that I made him feel like he was somebody because to me he was somebody. I didn't look at him and see a CD4 count and viral load; I looked at him and saw G.R.

People say that the average physician encounter lasts around 15 minutes, and I always worry that it won't be enough to give my patients the attention they deserve. After five minutes with G.R., that feels like plenty of time.

Jim Swakow

2013-2014 M2 Scholar



What Makes Us Fall?

I had a patient with HIV whom I thought was doing great and he was, as far as I could tell. He cooked healthy food for himself, he exercised regularly, took all of his medications and had a job that he enjoyed and worked hard at. Even more than that, he was genuinely upbeat and cheery any time I talked with him and visited him. He was someone who I thought I didn't need to worry about; he was taking care of himself. I still wanted to maintain regular contact with him, so I called him one day to say hello and catch up a bit. I was answered with a weak 'Hello' on the other end. "This is Marcus, how are you doing?" He had been sick for several days and at this point was unable to even get himself out of bed. I asked if he wanted to call a doctor or an ambulance, or if I should do so for him. "You don't know, man. Those guys, they treat you like shit." I was able to arrange for someone to pick him up and take him to see a doctor, but those words said more about him as a patient than anything I had learned about him so far. The same pride that drove him to stay healthy and positive was the one being taken away from him when he was treated without respect by those meant to provide care for him. This was important enough to him that he would allow himself to become seriously ill before seeking help, which is especially devastating to a person with HIV.

What is the most important thing that we can do for our patients? For every patient, there's a unique answer and approach. But do we even consider that respect might be the one thing we can give that will make the most difference? If lack of respect from us is what can make our patient fall, we are the ones that failed. We have to see the person first, before we see the disease.

Bo Marcus Gustafsson

2013-2014 M2 Scholar



I had a hard time choosing the program for the second year of PCM Scholars Program, since I had little to no experience with any patient population except geriatrics—and who doesn't have that? I narrowed it down to the two populations that faced some stigma—homelessness and HIV/AIDS—and ended up going with the latter. I walked into it, as best as I could tell from running around in my unconscious, without any prejudices against that population. However, that's not to say that I didn't feel naïve to the actual challenges faced by these people.

All of our patient-centered work centered around Project Vida, a wonderful community center that works with exactly that population. The first thing our group got involved with was joining into a group therapy discussion, whose following names have all been changed for confidentiality. Our group introduced ourselves as second-year medical students. After that I don't remember if we directed the conversation or if we were just part of the dialogue, but the conversation took off shortly after introductions were made. The fact that stigma was an issue wasn't surprising, but it was my first, well, first-hand account of that problem. Maria said that if you get labeled as having 'bad blood', some people avoid you like you have some kind of modern-day leprosy, and that makes it really hard to know who you can trust to back you up when things get tough. We heard the story of another man in another session who said that when he was young and got his diagnosis, his aunts would wear face masks whenever he was near them and lost all their support. His cousin found him at a bridge hesitating to jump because he was afraid he might injure someone in a car down below, and got him turned around.

What did surprise me was how difficult it was to take the medications used to treat HIV. It was one of the most-talked-about topics in the session. One individual, Theo, said that taking medications can be "so nasty", and his face looked so dour I briefly wondered if he might cry. People jumped in on that comment to affirm his confession, and the language that was used in Project Vida was not compliance—I never once heard that word—but adherence. While these were only the two biggest struggles, the energy level in the room was just incredible, and it felt like these groups were a really key part of maintaining a healthy lifestyle for these folks. Community and relationships stood out to me as the best medicine, and the lack thereof was the greatest struggle.

Jordan Hoerr

2014-2015 M2 Scholar

Project VIDA's Patient-centered Care

What I am taking away from this year's work with Project VIDA—an HIV/AIDS community center located in Southwest Chicago—and my client is a better appreciation of just how much a community center can contribute to the health of my future patients. Throughout my time at Project VIDA, I was continually amazed by the staff's dedication and the depth and quality of services offered to clients. I truly feel that Project VIDA encompasses the essence of Patient Centered Care. Each case manager and staff member gets to know their clients individually and recognizes that each client's needs and desires in life are different and therefore will require a different approach. And although case managers realize that access and adherence to Highly Active Antiretroviral Therapy (HAART) is essential to the successful treatment of HIV, they also recognize that successful treatment of HIV requires addressing other factors that led someone to acquire HIV in the first place. Such factors may include unsafe living situations, poor access to food, lack of transportation, psychological disorders and lack of a social support group. Project VIDA offers programs that tackle many of these health-related factors and will go out of their way to link clients to any other resources not offered.

A solid support network is protective and beneficial for a variety of physical and psychological conditions and HIV is no exception. Project VIDA's weekly psychosocial group sessions provide this support network for their clients. They provide a safe place for HIV positive individuals in the community to come together, support one another and delve into a wide variety of important topics such as depression, anger management and HIV medication updates. My client, S.V. has been regularly attending groups for 10 years now, which goes to show just how much clients value what group has to offer. As part of PCM, I was involved in leading 2 group sessions that revolved around stress reduction techniques (exercise, sleep, meditation, journaling), aging and HIV and HIV-associated stigma. Almost every client contributed to the discussions we had and many were incredibly open about sharing their stories. The openness and willingness to participate that clients display at Project VIDA says a lot about the safe, comfortable foundation that Project VIDA has laid for them. A positive group setting like this is something a physician cannot provide for their patients. But physicians can take the time to learn about and visit different community centers or support groups in the area they work and determine which ones to recommend to their patients. This is absolutely something I plan on doing when I am practicing in the future and would not have realized the actual importance of a solid support network without my experience at Project VIDA this year.

Nicole Bronson
2014-2015 M2 Scholar



Grief

He seemed so quiet
He never asked me for much
He had no questions

I wanted to help
To educate and teach him
I felt so useless

Soon I noticed he
Didn't really need that much
Instruction or help

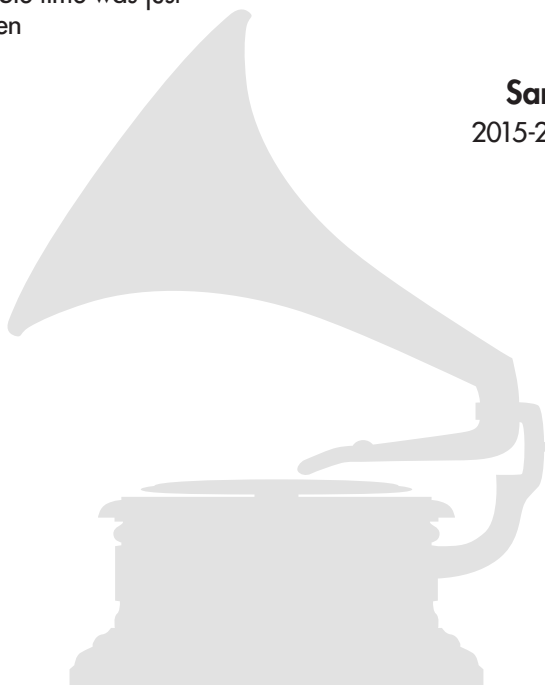
Until one day when
He told me his brother passed
I was so speechless

I said "I'm sorry
I can't imagine how hard
It must be for you

How sad you must feel"
I listened to him tell me
About the bereaved

Then, I knew what he
Needed the whole time was just
Someone to listen

Samantha Glass
2015-2016 M2 Scholar



Reading the Open Book of My Client's Life

The case manager introduced us, letting RC know I was there to see if I could be of assistance in any aspect of his care or his daily challenges. As we started talking, it became apparent that while RC had HIV, it was in fact one of the least challenging obstacles affecting his daily life.

I learned that RC had also been battling schizophrenia for several years, and his only source of income was his Social Security checks, with which he constantly struggled to make ends meet. After paying his monthly rent, he barely had enough left over for basic daily meals, let alone basic amenities. It was always a challenge for him to keep his appointments with his doctor or case manager at Project Vida because he relied on public transportation, sometimes with a commute of two hours one way. On top of this, he had recently found out that he was \$4000 in debt from community college classes he had taken years ago. The thought of the consequences of not being able to pay off this debt were so overwhelming for RC that he had trouble sleeping but had no idea how to start saving to pay it off.

We decided this was something I could assist him with, in talking over his finances to come up with a long-term way of organizing and managing his spending better. My first instinct was to question whether I should take on this responsibility, as with no background in finance, it did not seem like I would be at all resourceful with helping RC in this aspect. We decided we would go over his bills for the past several months at our next discussion.

As we delved into this, even just talking about his finances and taking a closer look at how he allocated his money made RC more conscious about his spending and helped him feel more in control of his daily functioning. It was amazing how something that took so little effort on my behalf could make a significant difference in promoting RC's well-being.

I realized that just the simple gesture of someone else taking an interest in RC's life beyond his medical diagnosis to look at the other challenges affecting his wellbeing was empowering for him. RC was immediately willing to show me his life as an open book—I was a complete stranger yet because I was a student physician, he generously trusted me with the most intimate details of his life. I did not need a business degree to take a few extra moments to help a patient find more structure in his day. RC reminded me of the dynamic and wholesome person behind every patient chart and diagnosis – and how crucial it is to push ourselves one step further in striving to better understand the confounding aspects of the patient's life that may initially seem unrelated to health when promoting their well-being.

Ashley Patel

2015-2016 M2 Scholar



After working at health clinics in West Africa, I thought I knew the typical presentation of HIV patients. Opportunistic infections and weight loss overtly consumed patients there. My experience at Project Vida forced me to look deeper, past physical suffering. My client V was energetic and muscular. On the outside, I could never guess that he was HIV+. Even after our initial meeting, I was amazed at how upbeat and optimistic he sounded about his future. He spoke of his world travels and his successful fashion design career. I assumed that his HIV status did not affect him. My home visits changed this perception.

Walking into his living room, I was amazed at this incredible, seemingly bright piece of art hanging on the wall. He acknowledged that he painted the scene and offered to explain it to me. The women stand among the colorful hues of the room, feeling comfort in the area with clothing and art scattered on the floor. She stares in the distance at a hospital scene- a place that fills her with uneasiness. Leaving his home, I wondered how much of this painting represents V. He mentioned that he had a negative experience with the doctor who diagnosed him with HIV but brushed it off as something in the past that no longer affected him. Does this painting suggest otherwise? Did that crucial encounter with a physician leave him to suffer from deep-seated, hidden anxiety for the rest of his life? How can I avoid causing such anxiety in my future patients, or identify those who may already be suffering in this way?

Elizabeth Nagel
2015-2016 M2 Scholar



Why Doctors Become Jaded

I signed up for the Service Learning Program because I hoped that forming a longitudinal relationship with a client and being exposed to their lives outside of the doctor's office would help personalize the theory of intersectionality of health outcomes and keep me from becoming a jaded physician, one of my biggest fears. I was very excited to start working with my client. After being paired with an elderly HIV positive man through Project Vida, we planned to meet at the site to discuss what we could do together throughout the course of the next few months.

Project Vida is about 45 minutes from campus and about the same from home, and I set out that afternoon with a list of possible topics to discuss and tasks to complete. I arrived and went to find the case worker that was assigned to the client, who greeted me and invited me into her office. I waited while she continued to do her work, and about 20 minutes later, we thought it might be a good idea to call the client to see if he was on his way. He answered the phone with a tone of surprise and said that he had forgotten about our appointment, and that he was not feeling well anyways, and wouldn't be coming in today. I was disappointed, but we rescheduled for the following week. The following week, I went in again, and my client was there. We had a great conversation while waiting for the case manager, and with her, we determined that we would be discussing the impact of HIV on the aging process over the next few appointments. We rescheduled again to have our first official meeting a couple of weeks after. On that next appointment day, I went in having studied and armed with points for discussion to answer the questions the client had asked. Once again, after my 45 minute commute, the case manager informed me that the client wouldn't be coming in. I was frustrated – I thought that it would have been reasonable to have heard about the cancellation before I made the commute down; after all, he had my contact information, as did Project Vida. We rescheduled, and before the newest appointment, I gave him a call to confirm that we'd be meeting. He said that he had forgotten again and that he wouldn't be able to make it. I felt myself growing increasingly frustrated. Especially with the upcoming exams, I felt like I was wasting my time preparing for our meetings and commuting to the site, without effort from the client's side.

But I had come into this program determined not to let these frustrations get to me. Instead, the next time we talked on the phone, my client and I discussed why he wasn't able to make his appointments. It turned out that a large part of the problem was that he didn't have a calendar to track his appointments, and often by the time people got into contact with him, it was too late to make the appointment. This was accompanied by a feeling of depression that occurs seasonally (during the winter) that makes it very difficult for him to leave his home. We discussed how he could add his appointments to his cellphone and set reminders ahead of time. We also discussed ways he might be able to access mental health resources through Project Vida and his health care team. I realized that privileges that I take for granted every day – my calendar, my smartphone, peers that are on the same schedules as I am as well as a supportive family and network of friends – are a huge part of what keep me on track, and that to pay



it forward, it is important to give patients/clients access to the same resources or else expect results to be different. I also realized that this was probably very typical of providers and clients everywhere – providers getting frustrated because of perceived lack of interest and clients presenting with a variety of barriers to accessing care. This experience was a short look into one way that provider burnout and perspective shift can come about, and I hope that by continuing to try to look past the superficial problem and find the root cause, I can avoid this burnout throughout my career.

Divya Verma

2015-2016 M2 Scholar



Healthy Living with HIV

I have learned common HIV patient presentations in lecture. I've been taught the specific infections that may compromise a patient's health throughout their lifetime. I have learned about the combination drug therapies used to treat the disease and the hopeful outcomes that I will be able to share with patients in my clinic someday. HIV care has come a long way. But I had never met anyone living with the disease. The thing is, it makes all the difference.

My patient was much less concerned about his HIV status than his struggle with diabetes. Together we designed and prepared diabetes-friendly recipes that fit his taste and limited budget. He invited me to visit his home and walked me through his daily medications. We cooked while we mapped out some dietary changes that he felt would fit into his lifestyle. We agreed that taking the stairs rather than the elevator to his apartment would be an easy way to build some activity into the day. Before we ate, he showed me how he injects insulin prior to each meal. I had never seen anyone use insulin before.

His openness and willingness to share about both medical and life experiences impressed me. So did his resilience. I was humbled to stand in his kitchen and learn so much. I am becoming more aware that beyond medical knowledge, my view of the community resources available to patients with complex disease needs to expand so that I may be successful supporting and advocating for my patients in a primary care setting. Our sessions together were also a great reminder that I will learn as much from my future patients as I will teach them. Together I hope that we can build partnerships and work as a team toward better health.

Katherine Venegas
2015-2016 M2 Scholar





homelessness

Advocacy for Patients' Needs

There are many people who almost never seek care from a doctor. They may avoid doctors for a myriad of reasons; lack of insurance, mistrust, embarrassment, fear, lack of time, and lack of health knowledge are just a few examples. Each time that we meet a patient, we have the privilege and responsibility to be their advocate and guide them through our health care system. That system can be daunting to most and, as we learn how to maneuver it ourselves, we gain greater ability to help others through it as well.

As I spoke with our homeless clients this year, I realized the rarity that it was for them to speak with a health care provider. Those who had seen a provider had stories of waiting, confusion, embarrassment and eventual discharge without any answers or needs met. I gradually saw a picture of people being lost in the shuffle, of their circumstances being ignored to the point that, in the end, the entire process was for nothing.

Other clients had stories that encouraged me, stories of long waits, fear, and confusion but that ended in someone, some provider, seeing them, truly seeing them and recognizing their struggle. Sometimes these stories ended in aid, in cure, and in health. The difference was always whether someone had taken the time to see these clients, talk with them, and help them in the ways they needed help. They guided them by giving them treatments that would work for their complicated lives and they connected them with services and providers who were able to fill the gaps.

I also heard stories of great need outside of health clinics and realized that if we are to ever improve the health of our patients struggling with homelessness, we must advocate for services to meet their basic needs. Sleep was highlighted over and over again and I heard of their struggle to find enough peace to be able to sleep. Homeless shelters are often chaotic and dangerous places for clients and many homeless choose to sleep on the street rather than go to a shelter. Some 24-hour establishments like coffee shops allow the homeless to sit, but as soon as they begin to doze, they have to leave. This takes its toll on the health of the homeless. I now understand how important it is that we, as a society, provide stable housing for the homeless for as long as they need to break out of the cycle. This may be years, but if we are to be a real community, one that ensures that others are safe and healthy, then we have to do our best to provide safe and peaceful shelter. This is a basic need that is not currently being met.

I see now that as a future doctor, my role is not only to see patients in the tiny microcosm of a health facility, but also to see them in their greater lives. I have to see the bigger picture and fight for what is essential to the health and well-being of the people in my community. We, as health care providers have a great privilege of societal trust and we must respect that trust by advocating for the people who need us most.

Michael Donovan
2012-2013 M2 Scholar





At first when I saw this picture taken by D, I immediately noticed how familiar this location appeared. After a closer inspection, I realized that this was the shelter where I drove by and walked by many times while headed to my girlfriend's house. Although I noticed the clients lining up to get into the shelter, I never really pay much attention to them. Now all that has changed because among those clients, D waits in line, hoping that there will be room for him at the shelter.

Through my visits and conversations with D, I began to realize that homelessness is not only a threat to substance abusers, gamblers or any other group of people that we stereotypically associate to being homeless. It is a threat to every single member of society. Before becoming homeless, D was a successful architect, a loving and caring husband and father. However, the near collapse of the economy heavily affected D, leaving him without a job. The immeasurable amount of problems that followed eventually led to a bitter divorce. From being a successful member of society, he had suddenly lost everything. I am sure that he never expected any of those events to happen to him, the same way that we believe homelessness is just something that will never happen to us. Now every time I drive by that shelter, I think of ways I can be of help to them because many of them had the same opportunities and experiences that I had, but a bad turn had quickly changed their lives.

I am happy for D because I know he will not give up. He is a bright, capable and willing man to change his life around. He will be working as a photographer this coming baseball season for the Cubs, so it will be sooner rather than later when I will no longer see him waiting in line to get into the shelter.

Danilo Fernandez
2012-2013 M2 Scholar

Homelessness



Going Outside

I think when we sequester ourselves into one environment, full of others all focused on the same goal, it can be easy to forget about everything else going on in the world. We talk about school, about professors, and our personal lives (until it inevitably turns back to school again). We study hard for exams, and then we celebrate the end of a series of finals with the only other people who know how hard we've worked. We put most things aside so we can learn all things imaginable about the human body. I can't even imagine how much major news occurred and went unnoticed, sometimes hearing about it a week later. When talking with my non-medical school friends, it's hard to believe that they don't find my preceptor's jokes nearly as funny as I do. But, oddly enough, it's true. They don't.

Especially during exam time, there's this tendency to be totally out of the loop, and stuck in your own world, concerned with only your problems. I'm not saying that there can be any other way. We withdraw and we focus, so that in the distant future, someone can leave us feeling better than when they came to us.

But, after exams are over, it's good to have something to pull me back. I think that's why I valued the PCM program so much this year. Every single time I visited the Community Engagement Program at the Lincoln Park Community Shelter, I remembered that there are other things going on in the world. I was reminded that there are thousands of people in Chicago alone who do not have a place to go at night, who live in fear of being harassed, beaten, or worse, killed. I was reminded that there are people who have to beg for money from complete strangers to get coats, hats, and gloves, so that they don't freeze to death during this city's unforgivable winters. I was reminded that there are people who have to wait for hours and hours to be seen by a physician, because the public hospital is so overrun and so understaffed. I was reminded that my problems are not really problems.

Sometimes, I couldn't believe the stories I heard. I met a man who'd been homeless for years, who was formerly an architect, who was married, who has children somewhere. But when his marriage fell apart, so did he. And so this highly skilled and educated man lost his home. It's difficult to find or keep a job when you don't have a mailing address, or when you can't always keep your clothes clean and neatly pressed, or when you sometimes get so little sleep that you begin hallucinating. How do you get back on your feet after all this?

I learned that you need to be prepared and have a plan, because anything could happen at any time. Even if you have a plan, you need to be prepared for the idea that it could fail, and that you could find yourself on the street, without a home or anywhere to go. I also learned how important it is to give back, no matter how busy you are. Imagine being so without help and support that you beg strangers for money – wouldn't you want help? It's vital to care for those around us and working in this homeless shelter for the past year reminded me of just that.

Jessica Kuppy
2012-2013 M2 Scholar

I will miss the Sunday afternoons that were dedicated to teaching or meeting with individuals who, with a home, might have their lives fall back into place. Every visit was a surprise because, depending on the weather, there would be more or less attendees. In the winter months, more individuals took advantage of the few hours inside a heated building, free hot shower, free meal, and the opportunity to do their laundry and to meet with a medical student to discuss their health concerns, if they desired.

I always hoped to see familiar faces, dreading that the individuals who spent their time talking to us had been physically hurt or become too ill to make it to this awesome program provided by Lincoln Park Community Shelter. As much as I wanted to see them again, when they didn't return, I ultimately tried to stay positive and consider that maybe they had been accepted in to a safe shelter, reunited with family or found a way out of homelessness.

Our Sunday sessions always started with half of the Service Learning Program (SLP) group presenting and the other half staying after the lecture and speaking to individuals who had health concerns. I always felt so proud of my classmates when they presented because it was clear how much time they had dedicated to simplifying health topics for an audience that would have a range of education/health literacy. For my presentations, I always included a map of locations to get the services I discussed, like locations for alcohol/smoking cessation and free meals. I really wanted to find a reason to give everyone maps because I imagined it would help them get around town and maybe help them make note of safe places to sleep or locations that handed out food.

The individuals I interviewed for health concerns really taught me a lot about what it's like to be homeless. Each individual had a unique story that got them in their circumstance, and I was grateful that they shared it with me and trusted me to help them with their health concerns. The time I spent with them was always a pleasure. Through this experience, I learned that as a physician I will have to approach patients with open-mindedness and concern so that I ask the right questions about housing, employment and health concerns in order to deliver high quality care. I aspire to be as compassionate and resourceful as the physician who took her time to lead our group.

Carol Rodriguez
2012-2013 M2 Scholar



Homelessness

I spent my year in the Patient-centered Medicine (PCM) Scholars Program attending Lincoln Park Community Shelter's Community Engagement Project, where homeless men and women could spend a few hours getting a hot meal, a shower, laundry, and other services. As medical students, we spent our time giving presentations on various health topics and speaking with the clients about their health concerns.

The shelter's project coordinator made a point of telling us how much the clients looked forward to us coming to speak with them. However, I feel we, as medical students, may have gotten more out of the encounter than the clients.

Aside from a valuable opportunity to practice our clinical skills, the clients taught us about what it means to be homeless and how to approach working with patients with needs beyond the medical. I learned that, in my future career, I will often have to go beyond the duties of a doctor and sometimes I will be called upon to do the job of a social worker, counselor, or a friend.

Speaking to clients, I was fortunate enough to hear about some of their daily troubles associated with being homeless. I spoke with clients about the difficulties of finding a safe place to sleep, getting access to transportation, staying warm, and other necessities I typically take for granted. While we would speak about the clients' health needs, I could appreciate why their health concerns were not always a high priority; it is hard to care about hypertension when one does not even have a place to sleep.

Our homelessness concentration leader spoke to us about the importance of advocating for our patients. We must not take for granted that our patients will have resources to get their medications or other means to take care of their health. We must know the ins and outs of the healthcare system and help our clients with ways to get affordable medications. We also must know resources to help our clients with their daily needs.

What impressed me about many of these clients, however, was their resourcefulness. They knew how to find ways to stay alive and relatively healthy. They found ways to get medications. They knew where they could sleep without being bothered. These were not the lazy people stereotypes would have you believe they are. These were people who just happened to be going through a tough time; unavoidable circumstances brought them into homelessness. Also, everyone had a different story. There was no one "type" of person experiencing homelessness. It made me remember that everyone, homeless or not, has their own troubles and their own story. We must never assume we know our patients before speaking with them.

On the whole, I appreciated the opportunity to speak with homeless clients and I learned so much from the experience. I'm thankful that UIC COM has such a program that allows students to learn that medicine is more than just knowing the right antibiotic to prescribe. It is about caring for patients and advocating for

them in any way we are able. I hope that one day I can be a physician that can effectively treat my patients has a whole person, understanding the many facets of health.

Erika Olson

2012-2013 M2 Scholar

Homelessness



Truth or Consequences

I learned a lot about the homeless population over this past year. My experience with one of the individuals really stuck with me. Let's call him John...

I first met John when he signed up to meet with the "doctors" (aka med students) on our first Sunday at the community outreach program. We sat down to talk and almost immediately John started to cry. I asked him why he was crying and he said it was allergies and then proceeded to tell me his life story of a family, career, big house and how he chose to give that up because he liked alcohol so much. He said he's happy on the streets and he is content with knowing he'll die an alcoholic. When I asked about trying to get help and get off the streets he was adamant that he is happy where he is and he'd rather die a happy drunk than a miserable sober.

Over the next 5 visits, John was always there and usually signed up to see the doctor. He never had a medical complaint. He really just wanted company and someone to listen to his story. I was touched by his resolve and was actually starting to believe that he was actively choosing and enjoying this lifestyle.

On our last visit, John came to the program stumbling and intoxicated. They tried to send him away but he fell and hit his head, so they decided to let him stay and try to sober him up. The whole 3 hours, John was upset and crying. Seeing him like this make me wonder if the John I'd seen so many times before was the truth or simply him trying to convince himself that he chose a lifestyle that was more likely a consequence.

Lauren Hughes
2013-2014 M2 Scholar



Flying Blind – A Patient History

B.H.

Patient is a 36-year old man with past history of visual problems presenting with loss of consciousness. He fell on his face while walking down the street around 10 this morning. At noon he was found unconscious a few blocks from the hospital. He regained consciousness around 7pm, and reports pain in the hand and nose. Hand pain is focused on the hypothenar eminence, is exacerbated by touch, and radiates into the wrist on wrist extension. Nose pain is located just below the glabella and is likewise exacerbated by contact. Patient also broke his eyeglasses.

I was walking down the street, and it was cold, so I had my hands in my pockets. I tripped on a curb, and I guess I couldn't break my fall, cause I fell and hit my nose. They told me it might be broken, and it still bleeds sometimes. They also told me I had a mild concussion. I've been kind of confused and clumsy since then—like, I just spilled a cup of coffee this morning, which is something I don't usually do.

Past Surgical History: Patient began having problem in his left eye when he was 6 years old. Surgery was performed to remove the left lens and, a few years later, to place a prosthetic.

I don't know what caused the problems in my eye, but I know they started when I was six. They gave me an artificial lens when I was 10, and then they replaced it when I was 16. I always remember the year they replaced it, because that was my first year at the group home.

Current medications: Zoloft for depression.

I started taking antidepressants because of a counselor at Marysville Academy. Marysville is like a high school in Des Plaines, Illinois for wards of the State, and a counselor there thought I was depressed.

I grew up in Inglewood. I was mostly raised by my auntie, but she got heart problems around the time I got my second lens replacement and couldn't take care of us anymore. My mom had schizophrenia, so she couldn't take care of us either, or my dad, well, he wasn't supposed to be living with us—I don't really want to talk about why not.

When DCFS found out that he was back in our house, they took me and my brothers and sisters, and sent us to different group homes. I went to Marysville with my younger brother, J.H. He lives in South Illinois now. I have another little brother, K.H., who lives in the projects, and a little sister, the youngest, who ended up getting adopted. My older brother and sister were too old to become wards, so they moved out on their own.

Past Medical History: Detached retina in left eye, 2001, resulting in unilateral blindness and left visual field deficits.



I passed through about a dozen group homes—10 kids in each one—but I finished high school at Marysville. When I was 18, they moved me to an independent living program in Northridge, where they pay for your home and your school, and I did a one-year program in auto repair at Lincoln Tech. After that I moved back to Chicago and got my own place in an SRO at 18th and Wabash. I had a job doing tire and oil changes at Montgomery Ward, but they cut my hours down and I couldn't pay my rent, so I had to leave. I was 22 then.

When I was 23 or 24, 2001 I guess it was, I slipped and hit my head. I was doing some repair work for a church deacon, who was helping me find somewhere to live. I was working in an old building—his house, actually—and the stairs collapsed underneath me. I felt okay when I stood up, but I saw a little red dot right here, around 10 o'clock. I went to Stroger, and they told me that I had detached my retina, but that they couldn't do anything if I didn't have insurance. Without surgery, there was nothing for me to do but wait until the retina detached completely. So over the next couple of days I just waited while the red spot got bigger and bigger. Now I don't see red out of that eye anymore. I see black.

Having no left eye makes it tough to live outside. Like, when I'm crossing the street, I have to turn my head all the way around to make sure I don't get hit by a car. Actually, the eye problem might be why I tripped and got the concussion. And I'm kind of paranoid that I'll lose sight in my good eye, like in another accident. I don't know what I'd do if that happened. I need to replace my glasses now, but I don't get my SSI money until the 19th. The first thing I'll do after I get the check from my payee is to go to LensCrafters.

Review of Systems: Psych – patient reports low mood and symptoms of depression.

Am I still depressed? Yeah, I guess so. I mean, I never thought I'd end up homeless. I imagined I'd be working and living in my own place.

If I had a wish, it would be to have a decent paying job—maybe as a diesel mechanic for the Metra. And a car...I'd love to have a car. Back when I was in the SRO, I had an '85 Crown Victoria, and every weekend that I didn't have to work I'd take it for a drive. They would be long drives, solo drives. I'd go to Indiana or Wisconsin sometimes—one weekend I went to the Dells and went on some of the rides. But it didn't matter where I was going. I'd just drive and listen to the radio. It didn't even matter what kind of music was on.

Social History: Patient has worked as a cashier and in automobile maintenance but is currently unemployed. Patient lacks insurance and is unable to provide an emergency contact.

For food, I just go to different churches in the area. Monday to Saturday, there's a window at St. Vincent DePaul that serves food at 8:30am. At 9am most days you can get soup at St. Josephatz—you know, like "jumpin' Jehosephatz?" On Monday and Saturday, Our Savior serves lunch, and on most nights, you can

get dinner at Temple Shalom on Lake Shore Drive, or Epiphany at Grace and Damen. I've gotten pretty good at keeping track of them, I guess.

A few years ago, I moved to Detroit with my cousin and older sister D.H.- the one who was too old to become a ward. I lived with them for a while and worked as a cashier. But I got tired of dealing with the public, and tired of being in Detroit, so I came back to Chicago.

Now I stay on the corner most nights, at Lincoln and Sheffield. There's a restaurant there—Etno's, you might know it. There's usually two other people out there, but they're people I know, so they don't mess with me. A couple of them even asked how I was doing after I got out of the hospital. Other nights I stay on the lakefront—you know the Theater on the Lake, by Fullerton? I like it there, because there aren't too many other people. Yeah, it gets windy, but you figure out how to deal with it. Like, depending on which way the wind blows, I move to the other side of the building.

Patient is unable to provide a home address.

Matt Stevenson
2012-2013 M2 Scholar

Homelessness



Drawing

I couldn't wait to see his art.

He would draw me a picture, he said. Drawing was his hobby.
I was excited to get a new glimpse into his life,
Something more than what I already knew: he was homeless, and he his
shoulder hurt.

I wanted to get a glimpse into what his passions were;
How does he choose what he draws?
Where does he get his inspiration from?
What guides his vision?

We talked more about his shoulder,
And I was happy to help him where I could;
Our pharmacy consisted of a box of
Over the counter medications.

Hopefully, these meds helped him,
So that he could draw more,
So that he could perform his daily tasks,
Without pain.

I never saw him after that day.
He was homeless, after all,
Always on the move.
I never saw his art.

But I do hope he keeps drawing.

Megha Shankar
2013-2014 M2 Scholar



I was admittedly nervous going into my first visit at the Community Engagement Program for the homeless...not because I thought I was incompetent or that I was afraid of the people, but rather that I had never sat down face-to-face with a homeless individual or said more than a few words, such as "sorry I don't have any money." In truth, I didn't know how I would be able to relate to them at all, because their lives were so different from what I was used to. What would I talk about? What types of things could I say that won't be construed as offensive?

In this first visit, we made a brief presentation about flu shots, and then broke out among the small tables of seated guests. I spoke with them a little more about the flu, but then just sat staring, in silence, thinking about what else to say. After a few moments, one of them asked another the only other thing that had been on my mind that afternoon: "What's going on in the Bears game?" I took a sigh of relief and jumped into the conversation, giving my two cents. We talked for the next few minutes about our beloved yet struggling football team, and suddenly I realized something very important. They were people just like anyone else. In fact, they didn't even "look" homeless! They opened up to me a little more about their lives and made it clear that the path to becoming homeless is not that far off the main highway; one stroke of bad luck, one illness, one mistake, one series of unfortunate events, one cycle seemingly impossible to break.

Soon after, we switched over to seeing individuals for their medical needs and I met with my first patient. Mike was a 36 year-old man presenting with foot blisters and requesting antibiotic ointment to prevent them from getting infected. I assured him that we could take care of that, and for thoroughness, I continued on taking a full history. In addition to having a few chronic physical conditions, I discovered that he suffered from bipolar disorder and that he was drinking a full case of beer per day. Mike was the first homeless patient I had seen, and my knee-jerk reaction was to blame him and his drinking for his homeless situation and to try to fix everything immediately. I asked a series of questions confirming his probable addiction and urged him to seek help. Of course, there were inherent problems to this approach. He lacked insurance, social support, and most importantly he wasn't ready for me telling him to get his life in order at that moment.

I met with one of the attending physicians, spewing out everything I had just learned and asking what we should do. She calmed me down and suggested that we just try to address one problem at a time. We gave him some ointment for his feet and provided some information about resources available in the city, should he choose to use them. He thanked me and then went on his way.

Over the course of several visits throughout the year, I refined my approach and became much more comfortable working with these patients. It helped to learn some of the logistics regarding access to health care and refuge, but what helped the most was understanding their day-to-day situation, gleaned by simply listening and avoiding judgment. There were multiple situations in which there was nothing I could realistically do to solve their problems, yet each time they thanked me just for being there to hear their story. They are often so used



to facing rejection in their everyday encounters that when someone is there to finally advocate for them, they may be more appreciative of that than anything else.

The homeless comprise a diverse group, and as such, cannot be stereotyped into one form or another. Each has their own story as to how they became homeless, what struggles they face, and how they are coping with their situation. There is a wide mix of hope, self-loathing, peace, fear, anxiety, remorse, and toughness. What they do have in common, though, is that no one likes being homeless, no one chose to be homeless, and each of them wants to break out of the cycle and emerge from their homelessness. As physicians, we might not have all of the answers and we might not be able to solve all of their problems. But we can certainly try- one person at a time.

Jeremy Kruger

2013-2014 M2 Scholar



This experience has made me reflect deeply on the organization of our health care system. Working with a transient population that lacks the stability of a permanent home and is particularly vulnerable to poor health outcomes, I have better recognized the gaps in our health care system. With increasing standardization of the practice of medicine, I fear we are losing some of the art. While large medical centers are efficient in organizing knowledge, resources, health care professionals, and the latest cutting-edge treatments, they demand the same neat, mechanical efficiency from its users, the patients. At the same time, with increasing medical care costs and the subsequent chaos of agents mediating the finances, achieving well-being demands navigating a complicated and messy transaction.

In this context, the Service Learning component of the Patient-centered Medicine (PCM) Scholars Program and our presence at the homeless shelter stands in stark contrast, stripped down to the basics of healing. We are beginners; students with limited medical knowledge and expertise. We do not yet practice evidence-based medicine or intuitively recognize patterns of pathology. Our clinical skills are far from developed and efficient. We gather patient histories circuitously, starting with the chief complaint, and then the HPI and then the story about how everyone jokingly calls him the “Mayor of Clark Street”. We bring our stethoscopes, a reflex hammer, one blood pressure cuff, and two boxes of medication, mostly for topical infections, allergies or congestion, antacids, and pain. We prepare educational handouts on accessing Medicaid, finding safe places to spend the night when winter becomes harsh and unrelenting, finding more specialized care at health centers motivated by service. But as beginners, we visit once every month and offer stable, predictable care. As students, we offer our curiosity, humility, and patience.

I stand in awe of how far medicine has advanced and at how quickly it is progressing. This progress rests on relentless efforts to quantify health and its care, meticulously measuring risks, assessing the values of different treatments, and standardizing care to be the best for the most. Yet, health is not quantifiable. It will always be organic, and volatile. The well-being of mind, body, and spirit has no formula and is unique for each individual. My experiences in SLP this year has made me appreciate the value of the basics in healing, the value of what we have to offer even as beginners in the art of medicine.

Shuvani Sanyal
2013-2014 M2 Scholar



Overcoming Biases to View the Homeless in a Patient-centered Manner

It is hard for me to admit that I have my own unconscious biases. Yet, I have them. We all do. I believe that instead of sweeping these biases underneath the rug, we need to identify them and try our hardest to change them. For this reason, I think that it was so important for me to be a part of the Homelessness concentration in the Service Learning Program (SLP) this year.

I feel that for many people, myself included, the term 'homeless' conjures up certain images, thoughts, or emotions that are unfounded stereotypes that ignore the true identity of these patients. After spending these last months working with this population, I can safely say that my biases have been broken down, and I now view this population in a far more patient-centered manner.

I am incredibly fortunate and blessed to have been able to work with this population this year. I found that their diverse, varied backgrounds and education levels were surprising to me. They asked probing questions, stimulated in-depth discussion, and many were far more knowledgeable than I had ever imagined. At the onset of each educational seminar, we never really knew what to expect. There were sessions in which we stayed mostly on topic, and other sessions in which we responded to questions such as 'What is plasma?' and 'Can you tell me more about my Giant Cell Arteritis?' We answered their questions to the best of our knowledge, but there were many questions that challenged us to go home and read a little more before coming back ready to fully answer. Through their discussions and questions, I really got to know this population. I now better understand their struggles, healthcare concerns, and overall needs. These experiences were fundamental in helping me to view them as they truly are, and not as some false stereotype I had conjured in my mind.

After this experience, I will be much more prepared to work with these patients as a physician. I am better equipped to provide practical resources and applicable material to help empower them to take control of their own health. A good understanding of a population is essential to providing patient-centered medicine, which is how I hope to always approach these patients in my future practice.

Jenna Spencer

2013-2014 M4 Scholar

The Spirit within Me Salutes the Spirit within You

Focus on the breath –
 Release and
 stop
 reliving
 regretting
 replaying.

Focus on the breath –
 Cleanse from within
 out.

Focus on the breath –
 Peer through and
 bend
 back
 before
 beyond.

Focus on the breath.

Ivy Zhu
 2014-2015 M2 Scholar



Listening

I was finishing the interview,
Making sure to summarize and clarify
But he already knew all that—
What his illnesses were
What medications he should be taking
What habits he needed to cut out
I asked if he was ready to take a step towards change
But he didn't want to make another empty promise to others; to himself
I asked if there was anything else I could do
He just needed someone who would listen
So I listened

His former life, his son, his fears
I got to know them pretty well over those few months
And I got to know him pretty well too
When he just needed to blow off steam
And when I needed to offer support and encouragement
He assured me he was fine
He just needed someone who would listen
So I listened

In those moments
The best I could do
The most I could do
Was to meet him where he was
And be someone who would listen
So I listened

Bryan Killian
2014-2015 M2 Scholar



138,000

There is a city within this city. It doesn't have a name because no one wants to claim it as their city.

No one calls it home.

It is a city of movement and uncertainty.

Its residents wake up, having slept poorly, and know that they must keep moving, shifting for reasons vague and concrete, always moving along.

It is a city of invisibility.

All of its residents hide out in the open, to be looked at but not seen.

If you look through someone enough times you may slowly assure yourself that they are not there, that they belong to another city or perhaps another world.

If you look through someone enough you may slowly assure them that they are not there.

It is a city of stories that no one will ever hear.

It is a city where second chances are very costly, and first chances don't always come first.

It is a city that is easier to get to than you think and is very hard to leave.

Its boundaries shift as its residents come and go but it is steadfast all along, the quite city within our city, the city that no one calls home.

Daniel Parsons
2014-2015 M2 Scholar



Reflections on Homelessness

When we think of homeless people, what pops into our minds are images familiar to any urbanite: panhandlers walking up to cars asking for change; worn-down individuals on the sidewalk slumped over cardboard signs; bodies wrapped in dirty blankets under bridges, overhangs, or in the doorways of businesses closed for the night. We might pass by them without much thought, having accepted them as a natural part of the landscape of our daily lives, or we might wonder, as I have from time to time, how can they live like this? How can they even survive?

Now, after having worked with the un-domiciled population as part of the Service Learning Program, I have a much better idea. One of the biggest revelations from my experience providing wellness checks to homeless individuals was simply how resilient they are. Despite their daily struggle of trying to find food and a place to sleep, trying to stay warm during Chicago's winters, having survived abuse from intimate partners or beatings from others one has encountered on the street, the people I met during my program were surprisingly upbeat and always friendly. They might face hardship on a different scale than the rest of us are used to, but they've adapted to handle it in a way that still allows them to appreciate life. That's not to say that their condition can't wear down on them – it certainly does, and a number of patients I interviewed suffered from depression – but their ability to take life as it comes and bounce back when it knocks them down is nothing short of awe-inspiring. One person I interviewed described himself as a warrior, which admittedly seemed self-aggrandizing at first, but I've since come to regard all of them as warriors, fighting their way through conditions that to the most people would seem unlivable.

That is why it upsets me so much when healthcare professionals treat homeless patients with less respect than they do other patients. This population already has to deal with so much, and they already feel marginalized by society. Can't we at least give them the same level of care and dignity as we do all of our other patients? I can understand how some practitioners may be jaded, thinking that it doesn't matter what diagnosis or recommendations they give to homeless patients because it often does little to improve their condition. There is much truth to that sentiment. Health problems among the homeless are largely secondary to the living out on the street. Such problems are better addressed by public policy, such as more affordable housing, than in a doctor's office. However, to deprive the highest quality medical care to people who already live in deprivation is a sad, unjustifiable irony. For many of the un-domiciled, their health might not improve no matter how many visits they make to the doctor, as long as they still live without a home; but by giving them the respect they deserve when they come into our hospitals, clinics, or offices, we can improve their quality of life by giving them back some of their sense of humanity that the street has leeched from them. These men and women are not lumps on the side of the road or hustlers to be avoided, but human beings, warriors in a life that has so often beaten them down.

Andrew Russell
2015-2016 M2 Scholar

Mindful Presence

This year the PCM Scholars Program reiterated some strong themes for me. I would like to share something simple that the experience reminded of. As a medical student conducting a patient history, I am constantly aware of the fine art of balancing rapport with the patient with my simultaneous thought process of a possible diagnosis and relevant questions to ask in order to come to one. However, this experience reminded me of the importance of being present with a patient.

Many of the guests we worked with at the Community Exchange Program had not seen a doctor for years and we may be the only opportunity they have to discuss their health with someone in the medical field. Knowing that I represented the 'health field' and that the representation I portrayed would affect my patient's future involvement with the health system made me more cognizant of my presence and also more confident in knowing that my fostering a partnership with my patient would make a difference for their future health.

I always feel empathetic with the patients I work with, but this experience reiterated the importance of taking the time to, after hearing my patient's story, to reciprocally communicate that empathy to the patient to consolidate that I heard them. I think the 'small things' we communicate with patients goes a long way and creates a more enriching experience, and our internal thought process (possible diagnostic paths or even feelings of being inept or inexperienced as a medical student) must be kept simmering and secondary to our intent listening and, importantly, validating of the patient's story and context. Even with time constraints I know I will be faced with on the wards next year, I hope to be more mindful of this important balance.

Amalia Hatcher

2015-2016 M2 Scholar



A Different Perspective

Before entering medical school, I spent some time working with youth experiencing homelessness in Washington DC. Families that had to leave their homes due to domestic violence or financial constraints were forced to enter the DC General family shelter for a safe place to stay. They could remain there, as a family, until a new home could be found for them. But, as hard as the non-profit staff worked to make sure that DC General was a home away from home, imagining a decrepit ex-hospital as a comforting and safe place for a child to play, a teenager to study and a mother to care for her newborn was an unquestionably difficult ask. But, there was a goal in mind - which social workers and a non-profit were working to help end this temporary nightmare and find a new permanent home.

But what do you do if this nightmare is not temporary? What if this situation was not really a nightmare per se, but the current living situation because there were no more options? These were the questions that I found most difficult to understand when I started working with the Community Engagement Program (CEP) at the Lincoln Park Community Shelter. Many of the homeless families I worked with in the past had the undisputable goal of returning to a permanent residence, a goal that was commonly accomplished. This was not the case for many of the patients at CEP and living on the street had become their lifestyle. Understanding that it was not my place to dictate when or how to get off of the street was an important first step to answering those questions and helping this patient population.

With every visit, it became clear that understanding their perspective was critical when addressing their health needs. Sure, routine screenings are appropriate for a PCP visit, but they may not be for a homeless patient complaining of suffering from frostbite due to inadequate clothing. The importance of asking that first question, "What would you like to discuss today?" weighed more heavily during these interviews than ones I had done in the past because it helped CEP guests open up and discuss their most pressing concerns. Many of my interviews with patients centered on health issues such as migraine, BP and glucose checks, but also included elements outside of their medical concerns. Topics of conversation also included problems with accessing healthcare, such as being unable to contact their assigned PCP, or being mistreated at the shelter in which they were residing. Understanding that every one of these issues is magnified for CEP guests and that, taken together, they impact their health in ways unlike other patient populations was a valuable lesson. In response to these discussions, I felt the most important role I played was letting the guests know what their options were in terms of over the counter medications, free clinics available to them and connecting them to a case manager if they decided to enter or change to a new shelter.

It was surprising to hear from many of the CEP guests that they had never heard of some of the options we provided for them. Taking that into consideration, this experience has taught me to be thorough with patients and be knowledgeable of the resources that are available to them because they may not know where to look, who to talk to or even what questions to ask

Bhavik Patel

2015-2016 M2 Scholar

Take the Lead

I realize that I cannot lead you
To where you do not want to tread
And so my pride foregone, unwilling
I let you take the lead

When I say no and you say yes
I must accept and understand
The only thing that I can do then
Is stay and hold your hand

Though your way differs from mine
Give accordance, I must
For when we have our difficult moments
I need to be the person you can trust

And so the truth comes out at last
When our minutes are over and long gone
Though I preach and beg and pander Your
choices are yours and yours alone

Krishna Constantino

2016-2017 M2 Scholar



An Eye—Opening Experience: Lincoln Park Homeless Shelter

I enjoyed my experience at Lincoln Park Homeless Shelter through the SLP Program. As an M2, I had the incredible opportunity to develop not just my medical skills but my patient interaction skills as well.

The stories that I came to hear while making these visits were very memorable. I also learned to be non-judgmental when listening to these stories. For instance, I was able to learn that the reason many of the residents could not take medications was due to financial reasons. Because I want to be in an urban, primary care setting as a future physician, I believe that this opportunity allowed me to hone my communication skills and my mindset when working with this patient population.

Narmeen Khan
2016-2017 M2 Scholar



Standing on the street
Cold, hungry, with no money
Can this life bring joy?

My things in one bag
People stare, why should I care?
You're just passersby

Felons and addicts,
Lazy and mentally ill,
Always forgotten

Stereotype me
But I have my own story
Take pause and listen

Perspectives will change
No judgments necessary
Homeless, not hopeless

Homelessness

Gina Lee

2016-2017 M2 Scholar



My motivation behind joining the Patient-centered Medicine Scholars Program was to have an experience that was completely unique to my time in medical school thus far. I saw PCM as an opportunity to break away from the sometimes all-consuming basic science curriculum and learn something new about a completely unique group of people. When I was placed in the Homelessness track this year, I was thrilled to be able to learn about the challenges faced by these people. The experience proved to be more challenging, stimulating and rewarding than I ever expected.

My first patient interaction began with a sense of urgency. My patient asked to have his blood pressure checked, as the last time he had a reading it had been high. I was optimistic that my patient had taken an interest in health maintenance and longitudinal issues such as blood pressure. As I began talking to him, he divulged that he had just used heroin ten minutes previously and that he had a previous high blood pressure reading the week before. Thus, I decided to measure his blood pressure immediately and continue with the interview after. After checking and double-checking, I kept measuring 210/110, so I immediately spoke with my PCM preceptor about recommending sending him to the emergency room. We spoke with him about his high blood pressure and our concern that he could be in real danger.

"Good," he replied.

That was not what I expected him to say. When we asked him why, he divulged that this was a long time coming for him. He had been depressed for years, and now with the recent death of his mother he was feeling that he had nothing to live for anymore. Heroin was his only diversion, and if he had the money he would likely overdose. I felt hopeless as a care provider and could not think of any way to help his situation. I truly did not know how to react.

I watched my PCM preceptor speak with him about his depression, the loss of his mother, his homeless situation, and his addiction. We listened as he told us his story. I learned the value of silence in a way that I had not appreciated before. He opened up to us about his living situation, his feelings of hopelessness, and his distrust of the medical system. I began to learn about some of the unique challenges he had faced throughout his life that led him to use heroin. At the end of our conversation, the patient declined going to the emergency room, but thanked us for listening. While this was not the result I was hoping for, I felt more prepared to ask difficult questions about housing insecurity, mental health, and drug addiction in the future.

After wrapping up our interaction, I learned that one of my classmates A.L. had spoken with the same patient the week prior. They discussed similar issues such as his high blood pressure, drug abuse, depression, and distrust for doctors. I only then realized why this patient had been so open with me that day. Alan speaking to this man the week before had begun to chip away at this patient's distrust for us as caregivers. This man wanted to be listened to, and he provided him that opportunity. For patients with the odds stacked against them, often all we can do as care providers is listen. However I will never underestimate the value of this task, as listening allowed me to make a small impact on my patient that day.

Steven Papastefan
2016-2017 M2 Scholar

Perspectives

"Genocide" is a hard word for me to hear her say. I wonder about her psychiatric health as she explains that homelessness is a purposeful institution established to rid society of people like her. At first, I am hesitant to talk with her - to ask her why she feels the way she does. As we continue talking, though, I discover that she is an intelligent woman with very real issues to address about homeless health. She talks about the realities of chronic sleep deprivation in the homeless as she recounts stories of being woken up every night by shelter employees or public transit officials, of shelter mistreatment as she shows me her broken finger from the last time she was forcefully thrown from shelter. In the back of my mind, I am thinking that the L is not made for sleeping on, nor are shelters wrong for asking rule-breakers to leave, but I realize the very real negative health consequences that she is experiencing every day as a product of her un-domiciled circumstance. From her perspective, I truly believe that the world looks the way she explains it to be, and I ask myself, "If I had gone through the same circumstances, or if I were currently in the same circumstance, might I arrive at the same conclusions?" Obviously, I cannot know the answer to that question as my life has been different from hers since day one, but I really think I might arrive at similar conclusions given her experiences and perspective.

I wonder how a doctor might approach this woman. Her stories might lead one to believe that she falls into some DSM-V categorization, maybe Paranoid Personality Disorder. I imagine a doctor would begin to think about a referral for Cognitive Behavioral Therapy. To be honest, I do not know; I have not learned enough as a medical student yet to determine the best medical plan of action for her. I wonder what my role is as a student, then. I feel out of my comfort zone as I talk to her in the context of a medical visit. I am not equipped to address the psychiatric needs that she may have, so I turn to what I do have - time and interest. Having majored in medical anthropology in undergrad, I understand how years of micro-aggression and institutional violence impact a person's reality, and so I listen to her talk about these things. I ask about her lived realities and the challenges they are posing on her health and well-being. I ask her about her life story and about how she has ended up where she has. I let her tell stories about how hard life has been, and as she vents, I tell her that her circumstances sound hard and that I cannot imagine having to deal with the same. I try my best to encourage her, but I really have no idea what to say. I tell her that she seems to be holding up well, and I commend her efforts to address and publicize homeless health issues. She thanks me for talking as I give her an antifungal cream for her feet - the only physical complaint that we addressed in the hour and a half discussion.

As I leave, I am thinking about the encounter and about what I would have liked to have been able to offer her. I wonder how much more helpful I would have been if I could think about her case in terms of Western biomedicine - taking a narrow doctor's perspective. Walking out, the shelter coordinator tells me



that the woman I was speaking to has never made it through an entire session without being asked to leave due to confrontation. As I struggled with figuring out what my role was in providing her care, I realized that my perspective had uniquely allowed me to spend time listening to her. I had come into the day thinking that my future perspective as a physician will be the one that will most help patients, but to be honest, I am not sure that is true. The interaction taught me to value perspective; to take her perspective into account, and to address patients from as broad a perspective as possible. I did not have medical knowledge to share with her, but I was able to listen and validate her feelings, to tell her that her thoughts were reasonable given her circumstances, and to encourage her to address the issues that she sees facing the health of the homeless population in Chicago. This lesson, more than any other, is what I hope to take with me as I move toward a career of service toward underserved patients who have perspectives very different from my own.

Chase Westra

2016-2017 M2 Scholar





immigrant & Refugee Health (IRH)



"I am relieved and happy to be living in a place that I can go and see the doctor," said the client at Heartland Alliance. She continued, "We were stripped of our citizenship in 1982. We are essentially stateless; we are not allowed to travel without official permission and are banned from owning land. We are discriminated against everywhere. We lived every day in constant fear that someone would hurt us or arrest us. We are also very grateful for the medical system here. In Burma and Malaysia there is no health insurance. You have to use your own money and because we were discriminated against it was impossible to make an appointment and see a doctor. Here, Heartland helps us make appointments and there are translators so we can receive the care we need and express our concerns to the doctor. I have been having constant headaches and foot pain that may be related to the change in weather and how cold it gets here. I went to the doctor and he said nothing was wrong, but I am still having my headaches."

This was just part of one story I heard while volunteering at Heartland Alliance. Through working with refugees I learned that providing health care goes beyond diagnosing and prescribing. It is also about building a relationship with the patient and working with him/her as a team to accomplish a goal. As future physicians, we need to be cognizant of the fact that our health care system can be complicated. We need to be advocates for our patients, helping them improve their health literacy and get the care they need. Empowering patients by teaching them to navigate the health care system is a crucial skill for future physicians. Talking to the refugees at Heartland Alliance, it is clear they want to learn about their health. They have many different concerns and are living in a new place where they may not speak the language. This presents a unique set of challenges. Something as simple as getting the right aspirin or cold medicine from the store can be completely new to them.

I have learned, through this experience, the importance of understanding the background of a patient. Finding out where they are from, how long they have been living here and how they are settling in can give helpful clues about their concerns and how to best help them. One of the most important things we can do is communicate and listen. I think this is especially important to remember when there is a language barrier with a patient. Communicating is essential for providing care. If the physician does not understand the patient's concerns and the patient does not understand what the physician is recommending or how to fill a prescription, the correct care may not actually be given. In these instances, it is important to talk through the plan with the patient, making sure they understand all the essential steps to getting the proper treatment. Because of this, working with a translator can be crucial. It is important to make the patient feel comfortable and that they are still in a conversation with their physician. Talking directly to the patient and looking at them while talking is a simple, yet essential step to this. It is important the patient feel comfortable with the translator, so he/she does not hold anything back.

Keeping in mind cultural differences, and the differences in our medical system, is crucial to making sure the best medical care is provided to the patient. The process could be completely new to them, so building trust and respect before

asking more sensitive questions or performing a physical exam is an essential step in providing the best care. During this experience I have often tried to imagine myself in the patients' shoes. Being in a new country, struggling to understand the language and now getting sick. Even trying to express how I would feel and what hurts would be a challenge. Getting a prescription, figuring how to get it filled and understanding how to properly take it is a simple process to many, but can be very complicated to some. As a future physician it is important, I take time to look at the process through the eyes of my patient to ensure they feel comfortable every step of the way. Caring for a patient is about teamwork. The physician and the patient must work together to come up with the best possible care, taking into account the concerns of the patient and the challenges he/she may face in receiving it. In doing so, teaching patients to understand what contributes to their health is essential.

I have learned much in my experience, most importantly that taking the context of patients into account in order to give them the best care is a crucial element in medicine.

Natalie Bodmer
2012-2013 M2 Scholar



We are Rohingya. After leaving Burma, we went to Malaysia. We were still not safe. Three months ago we came to the United States. We like it here because our children can go to school and play and do not have to live in fear. We hope that they will be able to progress in their schooling and attend college. Before, we had to live in fear but now we can live in safety. Life is hard though. We do not speak English, and this makes getting a job very difficult. Because this is our third month here, soon we will not have assistance and we will need to pay our own rent. One of our sons is working but this is not enough to pay for everything. Heartland helps us make appointments and set up job interviews. But it is still difficult, and we are worried about finding jobs. But we are still happier to be here than we were there.

- Rohingya couple

I arrived in the United States a few days ago and was sent to Chicago. I'm 16 years old. I'm from Guatemala. I am now living here in this center until I can be placed with my family. My uncle is living here in the United States, but my mother and the rest of my family remains in Guatemala. I am so nervous. I do not want to be here in this center, I want to start working. I need to pay off the fee my family paid to have me sent to the U.S. and then I need to start making money to send to my family. They are depending on me to make lots of money to send it back to them so they can travel here too. Getting here was not easy. I traveled from Guatemala to Mexico and then had to wait for several months in a gross center overcrowded with people waiting to cross the border. I am happy to be here because it will be better for my family, but crossing was not easy and now I am so worried about making money quickly to pay my debt and get my family here.

- 16 year old Guatemalan girl

These are two of the stories of people we met through the PCM Scholars Program this year. People like this Rohingya refugee family we got to work with at Heartland Alliance. And girls and children like this Guatemalan immigrant we met through our work at the International Children's Center in Chicago.

A refugee is a person who "owing to a well-founded fear of being persecuted on account of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such a fear, is unwilling to avail him/herself of the protection of that country." An immigrant is "a person who comes to a country to take up permanent residence."

Heartland Alliance works to provide services to refugees, asylees and immigrants arriving into the Chicagoland area. This ranges from being the initial faces that greet the refugees arriving at the airport to helping the center's participants in transitioning to life in the United States in almost every aspect you can think of. Heartland does everything from providing language and cultural assimilation classes to working as allies and advocates for new arrivals in navigating Chicago, finding job placement, registering children for school, and most pertinent to us in the medical field, navigating the healthcare system.

The International Children's Center provides housing, counseling and case management to children arriving in the United States. They are placed via the Department of Homeland Security into centers throughout the country, where they are provided with food, clothing, healthcare, and language lessons until they can be released to a relative living inside the United States.

Through working with both of these organizations, we got a glimpse at what the lives of immigrants and refugees arriving in the United States is like. We got the opportunity to see both the joys they have at being in America, which they identify with freedom and hope, and the monstrous obstacles that wait ahead of them in navigating our health care and other systems and transitioning into roles in society they did not perceive before they arrived.

While our role in "helping" was very limited to providing health education about nutrition, vaccinations, first aid, and basics of the healthcare system, we really received quite a bit more in return from hearing their stories and learning from them. Like many of our patient encounters through the PCM Scholars Program, this was another chance to peek into the lives of a population very different from ourselves and to help identify what life in the U.S. health care system can be like to "outsiders." We recognize the need for advocacy for these patients, as many come from war torn regions with histories of personal trauma and grief unthinkable to many of us. As one person described to me the idea of "good" and "bad" doctors as those willing to or unwilling to use interpreters in providing health care.

More than anything, this year in the PCM Scholars Program has left me astonished by the optimism and hope of so many refugees and immigrants despite their daily frustrations and obstacles in the United States. And I once again was able to identify how becoming a physician means so much more to me than understanding the science of medicine. It means also understanding the heart and soul, rhyme and reason, culture and politics behind this world of unique individuals.

Ann Bruno

2012-2013 M2 Scholar



Full Circle

Before I began attending medical school two short years ago, I spent my last summer working as a public health consultant for the United Nations High Commissioner for Refugees (UNHCR) in Amman, Jordan. I had just graduated with a master's degree in public health and was eager to reawaken my Arabic language skills while working with Iraqi and Syrian refugees.

While I was in Jordan, I spent my time learning stories of the refugees, working with them to derive strategies to deliver preventive health information effectively within their communities, and working with UNHCR to ensure adequate health care access and affordable or free services wherever possible. To describe the few months I spent in Jordan as a rollercoaster may be an understatement. The lows – and boy, were they low – had me questioning whether I could handle a career in this line of work that I was so passionate about. The highs were heartening, promising a beacon of light for these individuals, mere innocent bystanders who had been painfully thrown from their homes and support systems.

Day in and day out, I listened to heartbreaking stories of discrimination, torture, rape, and other countless forms of violence. I fought back tears as I listened, as their stories grabbed hold of my thoughts and shook me violently. Most of the stories ended on lighter notes; they were in Jordan now, where they were relatively safe. Some were still subjected to discrimination and violence, they said, but nothing like the atrocities they had endured before fleeing their homelands.

And almost always, the refugees' stories ended with a discussion of their hopes for the future. Many were defeated. They recognized a return to their homes was not possible. The Iraqis expressed confusion regarding their feelings towards America. On the one hand, they said the US is the reason their country has fallen apart. On the other hand, though, they expressed a longing for the free life they imagined in America. They said that if it weren't possible to be in their home country, America would be the next best thing. "Yes, that is my hope. My hope is that I will take my children to America." I heard this again and again from refugee after refugee after refugee. Knowing only a limited number of refugees are able to resettle in the US each year, I wondered how many, if any at all, would see this desire come to fruition.

Fast-forward one year to the beginning of my second year of medical school. I had been accepted to the Patient-centered Medicine (PCM) Scholars Program: Immigrant and Refugee concentration, one of the main reasons I chose University of Illinois for medical school. I found out that as a part of the Immigrant and Refugee Health concentration, we would be working with a group of refugees that included Iraqi refugees at Heartland Alliance.

It could not have been more serendipitous. I was able to see what one possible ending to the story of an Iraqi refugee—that for some of them, the hopes of a new start in the United States of America was not only attainable, but one they

are embracing to the fullest, with gratitude and excitement in every move they make. I learned of the new challenges they faced as refugees resettled in a completely foreign place, and we worked with them to try to ease them into the adjustment.

In the end, I was able to see it all come full circle. I could not be more grateful for the opportunity to participate in PCM, a program that has allowed me to maintain a connection with the public health side of me, reminding me daily of who I was before I began my medical school journey. While the program rejuvenated my passions for medicine and public health, the individuals we met while working at Heartland and ICC humbled me. The immense physical, psychological and emotional hardships they endured leave little to the imagination. Even still, they are some of the most optimistic and life-loving people I could ever have the fortune of meeting. It could not be more inspiring.

Aqsa Durrani

2012-2013 M2 Scholar



The Journey

"How did you get here?" Five simple words that taught me more about the subject of immigration than any class I have previously taken.

In January, our group met to watch *Which Way Home*, a documentary about two young boys traveling from Honduras to the United States by freight train. I remember seeing the movie and thinking just how crazy it was for these two boys to travel by themselves, expose themselves to countless dangers, just to be able to call the United States home. It was almost too much to be able to believe that this actually happened. In February, I made it out to the International Children's Center (ICC) and got to meet children, just like the ones from the movie, who had done just that; had traveled thousands of miles to the United States from Central America by themselves. I remember thinking, "When I was your age I was still getting lost at the supermarket!" The level of maturity in this group (ranging from eight to seventeen) was unbelievable. To say I had it easy growing up is an understatement.

PCM Scholars Program this year has broadened my perception of immigration. From the health presentations we gave, where there were numerous translators translating every word that came out of our mouths to the children at the ICC, I got to meet people from all over the world: Burma, Iraq, Bhutan and Cuba. Every single one had a different story to tell. It was a humbling experience that I will take with me forever in my career as a physician.

Jose Marquez

2012-2013 M2 Scholar



One Day I'll Go...

To the land of the rich and famous
Jobs everywhere and food a plenty
Mama can have beautiful things and she won't have to worry

Papa's gone ahead and found a job
I don't remember him anymore
His laugh, his scent, his face is all blurry

One day I'll go to America
One day I'll get a job and work hard to become wealthy
Then, it will be more than a story.

People have so many things going on in their lives. As we interact with one another and go about our daily lives, we only see the surface. We don't know how one person came from point A to point B. We don't know what they may have suffered through or what motivates them to get out of bed every morning.

For newly arrived immigrants, they may be fleeing persecution or may have left family and loved ones behind. They may have been motivated to travel based on the things they've heard about the United States and the relatively stable lives many Americans enjoy. It may seem like a fascinating story filled with unknown perils and perhaps a happy ending, so to speak, but this is the reality of the world we share. What may seem like a grand story to us is reality to them and what's a story to them seems a stark reality to us.

Wemi Adeyanju

2013-2014 M2 Scholar



Languages of Chicago

The many languages I heard from different corners of the room made my head spin. I was giving my first health seminar to recently resettled refugees at Heartland Alliance. Some of these languages, these cultures, I hadn't even heard of before. Soon I learned, however, that the Rohingya people, sitting in one corner of the room, are some of the most highly persecuted people in the world.

I understood some of the languages. In fact, at one point, I was asked to translate for the French-speaking woman from the DRC and the man from Chad. Even though I was familiar with the language, I was not prepared for some of their comments. When attempting to translate the nuances of sexual assault and molestation, the man said, "Ahhh, I understand, like Monica Lewinsky!!"

That was not exactly what I had been going for, so I simplified my approach. "The worst example of this is rape."

"Ahh," he responded, "that is very common in Africa."

I had another striking encounter with an Iraqi woman, who had worked doing laundry and housekeeping for the American army in Baghdad for seven years. Because of her American employer, she was targeted. One day, a group of men followed her as she walked home from work and shot at her. As she fled, she injured her back and leg. Today, she is constantly in immense pain. She can no longer sit comfortably and must stand or lie flat at all times. She has no insurance in the US and so cannot afford doctor appointments or effective pain relief.

Each individual refugee – as well as his or her culture, language, and reasons for leaving his or her home country – differs. Similarly, each person needs different types of support in achieving good health in America. A Rohingya, who hadn't received any health care at all until arriving in the US, appreciated any visit to the doctor, educational seminar, etc. The Chadian man worried more about his children than anything else; for him, his mental health depended heavily on the safety and well-being of his children. The Iraqi, who received good health care for free for her entire life in Baghdad, was outraged at the inequality of the American system, at the expense of health care without insurance, that she had to wait for hours in the waiting room and for hours to receive treatment. In Arabic, she exclaimed, "It's an emergency! I can't manage to wait for hours – if I could, I would wait to see the doctor tomorrow."

Heartland Alliance does great things to support their clients' health. They work tirelessly to understand their patients, where they come from, and what they expect and need in health care. They find translators to make their clients comfortable and understand how to live and function in the US. But none of the Heartland staff are doctors or nurses; therefore, most of the responsibility for these patients' health lies on us, the health care team. Regardless of the refugees' knowledge of English, we need to help them learn the language of the American health care.

Ann Schraufnagel
2012-2013 M2 Scholar

I've always felt divided on the issue of medical practitioners' obligation to practice global health or serve in another country. We have what seem to be endless amounts of problems with our healthcare system AND how it's delivered to patients here; therefore, going somewhere else to help someone really never made sense to me. But, at the same time, I wasn't ignorant to the fact that healthcare is much worse in MANY other places throughout the world. As with all things you don't quite understand, I wanted to learn more and further develop my opinions.

My travel outside of the U.S. was hindered in many ways for most of my young adulthood – whether it was because my passport needed to be renewed or because I simply didn't have the time or money to leave my friends and family behind for an “educational experience”. In my sophomore year of college, a summer opportunity opened up for me to teach remedial English, Reading, and Math to grade school kids in Park City, Utah. This community was made up of newly-immigrated or first-generation Hispanic American families from Mexico and Guatemala. I signed up right away, thinking, “I like speaking Spanish, teaching, and who doesn't love kids? This will be great!” Little did I know this would be my first of many exposures to immigrant populations, and that it would eventually bridge my views concerning global versus local/public health.

My teaching job required MUCH more than teaching. Several times, the other teachers and I would find ourselves going to our students' apartments to help their families fill out (what we would think to be) simple forms for say... school registration. Our healthcare system, for all its wonders, was completely foreign to them as well. We would spend HOURS with those families, helping them with anything and everything we could. But what I'll remember from that summer most of all is the immense gratitude we received. We rarely left without a little gift for our time spent with the families.

Over the next few years and similar experiences, I realized that caring for immigrant families was something that bridged everything I loved about local public health and global health work. I was meeting people with amazing, out of this world, made-for-TV-movie stories of hardship and miracles. Every person had something to teach me that, most of the time, was not about medicine, but about livelihood. At the same time, I was helping people within our own American health system and other infrastructures and advocating for them along the way.

So, really, there was no other choice for me but the Immigrant and Refugee Health concentration for my M2 Services Learning Program (SLP). And I was not disappointed with the experience. In many ways it was the same as what I'd done before: teaching, interacting with people of different cultures, etc. But as no two people are the same, so also are no two interactions. Again, I learned so much, not just about the actual people I worked with, but about their previous circumstances, their worldviews... and some were quite surprising!

Yet this time, the stakes seemed higher. We weren't college kids looking for “educational experiences” anymore. We were in a position of relative power



and respect. And so our obligation increased to help, serve, and meet the needs of a very specific population, straddling two worlds with different rules, ways of life, and healthcare systems. This obligation felt very real to me every time we presented a topic at Heartland Alliance to new adult refugees or when I chatted with an immigrant child at the International Children's Center while performing their physical exam. But it was one that I enjoyed and will continue to enjoy as I straddle local and global communities with this population.

Lindsay Schwartz
2012-2013 M2 Scholar



A Story for Someone Who Will Listen

I asked him where he was from.

His rough reply:

I am from Myanmar. You may know it as Burma. Most of my family is still there and to protect them I would prefer not to share my name. My family and I are Rohingya, and as such we have never been accepted or acknowledged by the Burmese government; our people have never been truly free. I was the oldest boy in my family. My father farmed and I worked with him, attending school whenever I could. Growing up, the military was always the largest source of danger in our lives. At any time they would grab random men and boys and make them walk hundreds of kilometers carrying goods and supplies for days and days. If someone was unable to do what the military needed, they would be subjected to violence, or shot, left for dead, and replaced with a new man from whichever village was closest. The women didn't fare any better. Soldiers would enter homes and steal women, raping them and either kidnapping them to be raped more, or discarding them whenever they were done. My parents were constantly afraid. Afraid my brothers or I would be taken with no way to keep track of our wellbeing. Afraid one of my sisters would be kidnapped or raped. No one could stand up or fight back because they would kill us without thought. We were all at their mercy. I was forced to watch soldiers rape my cousin, unable to do anything to stop them. In 1993 when I was 21, my parents convinced me to flee.

I could tell that the words had been waiting to come out – for someone to ask, someone to listen. His story continued through 20 more years, and three more countries. Now he is here, in Chicago with two children and a wife. His family struggles to adjust, and he is working hard to try and make ends meet. In a place where the native tongue, English, is his fourth language, his words are difficult to understand. His story is difficult to grasp. But he is waiting to share.

He explains:

I am so grateful to have been able to come to the United States. It has only been a month and things are not easy here, we are all struggling to adjust. But for the first time in my life I am free. I am 40 years old, and soon, for the first time in my entire life, I will be a citizen somewhere.

He seems very grateful for whatever my small role was in helping him understand the US and how to live a healthy life.

I am more grateful for everything he has taught me.

Meagan Appelman

2012-2013 M2 Scholar



Physicians and Refugees: Mutually Navigating New Terrain

Upon entering medical school a lot is expected of you: you need to keep up with your coursework, find a mentor, pad your resume with clubs and activities, and figure out what specialty you are going to pursue. For many, this quickly becomes overwhelming. Worse, then, is when a family member asks you what to do about a particular symptom because, even after all those long hours of learning, you have no idea what to tell them.

An incoming refugee faces different stresses and expectations. They need to keep up with daily living requirements like food and hygiene, find a job, and attempt to reach out in the community for social support. At the same time, however, they may come to the same position as the medical student: what do they do about a particular health concern?

If this is a difficult situation for new medical students, who mostly have lived in this country for at least 20 years, imagine the added obstacles of being a refugee. The language is different, the system is entirely different from what you just left, and your relatives and friends are few to none (any that are around haven't lived here long either). You have little money and you're not even sure if you need to pay for healthcare to begin with. You can't read English to know when you're near a health care facility and if you can you have no idea which might have a translator for you and when that translator may be available. In all reality you don't even know why your child needs to see a doctor but he's been having trouble breathing all spring and last time you brought him to the emergency department the nurses yelled at you and the doctor walked away angrily when he found out that you don't speak much English.

On top of all of this, the healthcare system is in a period of transition and even many Americans are at a loss as to where to turn. It is easy to see, then, how quickly the challenges mount up for the refugee population. What may not be so obvious is how readily they listen to medical advice; how willing they are to try to adjust to their new situation; how eager they are to ask questions and to learn. In the end it is not so much a resistance to adapt to US healthcare as it is an inability to know how to adapt. If we can learn to understand their difficulties, to see them as just another human trying to survive in a new world, and to take the time to help them achieve a plan that they can understand and are capable of following, we can improve not only their health but their ability to regain control of their lives altogether.

Andy Bellino

2013-2014 M2 Scholar

You just have to stick the needle in and push. It really is almost that easy. Stick the subcutaneous vaccines subcutaneously; you should see the needle through the fragile skin in superficial injections; intramuscular immunizations go straight into that deltoid. You know enough anatomy now, and you've done enough physical exams to figure this out. Maybe you remember your professor taking the deltoid of your cadaver in his hands and tracing the triangle that gives it its name, and maybe you think of this when you push that needle in all the way. Maybe you remember holding it between your fingers while you dissected the brachial plexus, the bulk of it in the larger bodies, and the astounding lack thereof in the woman whose cause of death was merely "failure to thrive" – words on her toe tag that struck you as just as emaciated as her frail body. Maybe now you're wondering whether this needle really is too big. Does it have to be this big? Maybe you should stop thinking about the anatomy after all.

Maybe you should think about the immunology instead. Even now the vasculature is absorbing these molecules and immune cells are recognizing them as antigens. Soon antibodies will be formed so that in five years, if this fourteen-year-old girl sitting stoic, eyeing the needles, in front of you is exposed to hepatitis B, she'll be okay. But what else will come with that hep B exposure? Will she be safe? Will she know how to take care of herself? Will your Spanish be better than so you can explain all this to her? Will you ever see her again? Maybe you should stop thinking about the immunology.

Maybe you shouldn't think about much of anything. Because this girl is squirming under your next needle and you can't, after all, vaccinate her against jetlag, or missing her parents, or dashed hopes. I said it was supposed to be easy, remember?

Monica Samelson

2013-2014 M2 Scholar



Cultural Communication

This year our role was to teach cultural competency classes about health in America to refugees who recently arrived in the US. This was a great experience and allowed me to learn from many unique individuals. Surprisingly, through my role as a lecturer, my biggest take-away was the importance and effectiveness of listening. After the first few lectures, the staff at Heartland Alliance instructed us to begin class with a discussion. These discussions became critical to enhancing our ability to teach class in an audience-directed manner.

One of the most successful classes we had was about breastfeeding. I was teaching along with another male student to only male refugees. Before teaching this course, we worried that the male audience would not be interested in breastfeeding. However, we began the class by asking the refugees about breastfeeding practices in the countries which they came from (mainly Iraq and Burma). From this we learned important information that would help drive our talk. For example, the Koran states that a woman should breastfeed a child for 2 years; this is the same recommendation as the WHO in 2014. We also learned that many foreigners believe that women in America don't breastfeed because American mothers believe that breastfeeding will deform their breasts. This discussion presented us with obstacles that deter refugee families from breastfeeding and provided us with information that allowed us to better connect with the audience.

The information gathered through the introductory discussions served as a great example of why health care professionals should ask questions intended to learn more about the patient's culture at the onset of a patient encounter. This can help health care workers direct the interview in a more efficient manner. It also will improve care for all the patients that share a similar background to that patient. In addition, understanding a patient's beliefs will help health care professionals provide more effective and more patient-oriented care.

JJ Parker

2014-2015 M2 Scholar

New Hope

Into unbound, uncharted frontiers

Leaving everything behind, but shedding no tears

Into the light, knowing no fear

Never has one's conscious been so clear

Opportunities and possibilities await

The past struggles I will abate

Obstacles and challenges there may be

Like a bird with new wings, I am now set free

Daniel Wang

2014-2015 M2 Scholar



From all across the globe they come,
Eager to share stories of their own,
A listening ear we provided,
On prevention and healthcare in US we guided,

Empowered I felt teaching these women of issues taboo in their lands,
Empowered they became sharing stories they had suppressed beforehand,
So grateful I am to this service learning program,
Which opened up a whole new world for me to serve at Heartland.

Devashree Dave
2014-2015 M2 Scholar



The boys at the International Children's Reception Center (ICRC) were only 10 to 17-years-old, though they have gone through more hardship and displayed more resilience than most adults will ever have to in a lifetime. When we first walked into ICRC, we were greeted by polite, though raucous boys whose excitement and happiness at seeing us almost made me forget that they had to embark on a dangerous journey without their parents or a familiar adult in order to be there.

Our first teaching session, Nutrition, was lighthearted and fun. The kids enthusiastically participated in the discussion – guessing how many calories were in popular food items (“what do you mean there’s as many calories in a burger as there is in a Starbucks frap?”) and expressing genuine shock and disappointment when they learned what a serving size meant (“no! In America, they don’t eat until they get full?”). It was a teaching moment for us as well, when we realized that some of the nutritional recommendations that we typically make were not realistic for this group. For example, we had to find other sources of dietary protein aside from milk, meat, and eggs because of religious and health constraints.

Our second and third teaching sessions, Puberty & Sexual Health and Drugs & Alcohol, were even more eye-opening. When preparing for the talk, we learned that some of the boys already have a history of physical/sexual trauma and drug/alcohol abuse. We needed to be more sensitive in our presentation. In the US, high school “sex ed” talks are stereotypically lighthearted and meant to be preventative; for these kids, these topics are instead difficult and possibly therapeutic. This moment taught me to never assume that I know what a patient has gone through, and to make sure to be thorough in my history taking. Learning to be comfortable with asking the more personal components of the social history is a vital part of becoming a good doctor, and I’m humbled that my experience at the ICRC helped me take the first steps in doing so.

Eden Liu

2015-2016 M2 Scholar



Preserving the Bucket

A room of 50 kids, all of them illegal immigrants, with likely none of them having a clear path to citizenship. The sacrifice, however, was made in search for greener pastures, which only highlights the severity of the conditions that must have compelled their families to invest a life savings in a journey that lasted weeks to months, marked with uncertainty, to come to a country where they will be resigned to a life as second class citizens (although even that classification is a misrepresentation-they won't be citizens at all).

As we worked with these kids from India and Central America, giving them short lessons on puberty, hygiene, and drug, I began to wonder why I was given so much institutional privilege and advantage while they had none of that. As a citizen of the United States I benefit from a plethora of services that are earmarked for citizens only and have the ability to live in one of the world's greatest countries. Living in the United States, on balance, is privilege, so what makes its citizens fundamentally more deserving of this privilege than non-citizens?

On the one hand, there are taxes, after all a citizen pays into the services that the government provides. If someone is not paying their fair share, they should not benefit from the services therein. But this can be easily reversed, if someone immigrates to America they can begin to pay into the system and then earn the downstream government services that they benefit from. Additionally there may be the concern of population control, but in reality, if it was not for immigration, the United States would be shrinking, our reproductive demographics are similar to Japan's, a country riddled with the problem of dwindling youth and growing elderly population. Immigration keeps us afloat, and the United States, a country with a modest (for its size) population of 350 million, has the carrying capacity for many more people. Even if we decided that 350 million was an arbitrarily determined optimal number, immigration would be unlikely to cause a profound increase and we would be able to oscillate at that number with the appropriate policy mechanisms in place.

So if it's not unearned government services, and it's not really about population, why do we prevent illegal immigrants from having a path to citizenship? Why have we determined that these people who came to America in pursuit of the same freedoms the citizens of the country enjoy are unworthy of those privileges and ought to be sent back from where they came? The real answer is rooted in a xenophobic notion of what makes the United States a first world country. The notion is that the United States, somewhere along the lines, made excellent decisions, fueled by excellent individuals, and built one of the world's most infrastructural sound countries with a large middle class where many people enjoyed a quality lifestyle and upwards mobility was available to everyone. Ignoring the fact that this notion itself is rooted in quite a bit of myth, the narrative continues that those individuals and their descendants have earned the right to live in this land, and that allowing immigrants into the country could ruin the harmony and balance that makes the country great. In other words, we have a utopian society thing going on here (or did once upon a time) and if we take

citizens from other countries it could ruin everything. People who believe this narrative envision America to be a bucket of pure milk, white and pristine, if you add dirt into the bucket, it will ruin everything.

What this false narrative overlooks is that while the United States is indeed a world leader, and an objectively excellent country, its excellence comes from the very immigrant population some have come to fear. Ultimately, we are all immigrants to this country, though some more generations removed than others, and it is the tenacious immigrant work ethic that fuels every successful industry in America today. Immigrants and people who espoused the immigrant grittiness passed down through generations built the infrastructure. So to change course and reject the very people who made America in the first place would certainly be a recipe for disaster. In biology class I was taught that the more species diversity in an ecological community, the more primed for success that group would be. In economics I was told that diversifying my portfolio would make my investments safer and increase their opportunity for growth. Diversity correlates with strength, and the strength of our nation is built on our various backgrounds and colors.

We stood in front of a room of 50 kids, all of them illegal immigrants, with likely none of them having a clear path to citizenship. What could they be thinking? What could their concerns be? They must be concerned about the threat of deportation, I thought, or maybe they took solace in the fact that they have preserved a life of security for their future generations. "Any questions?" we asked them tepidly, unsure what complex questions would erupt forth. "Why do we get pimples!" a 16-year-old boy asked emphatically, spilling out of his seat. We paused--caught off guard by the juvenile nature of the question--and then remembered that these were still kids, regardless of the context in which we were meeting them. The childish nature of the question was endearing, and we were happy and eager to answer a question we were qualified to address. It was a stark reminder of how these kids were not a threat, but a potential building block in the foundation of our future.

Omar Jamil

2015-2016 M2 Scholar



Child Refugees

A group of children
Unified by their journey
Searching for new life

Representation
Many cultures, many lands
All under one roof

Hours, days, weeks, months, years
Waiting for citizenship
Fates undecided

Though tired, they smile
They laugh, they question, they think
Learning about health

Shani Chibber
2015-2016 M2 Scholar



If you turn on the TV today, there is a good chance you'll hear a politician or news pundit discussing refugees. Both sides of the political spectrum talk about where these refugees are coming from and what to do with them; rarely, however, do you hear them talking about who these refugees are as people. When I joined the immigrant & refugee group of the PCM Service Learning Program, I wasn't sure who these refugees were either. Sure, I had some ideas, but I didn't know what it would be like to interact with them on a personal level. Would they welcome me? Would they be angry with their situation? Would they be afraid?

Such questions swirled in my head as I began my first health lecture in front of 40 refugee teenagers. Most of them were from Central or South America, and they ranged in age from 9-16 years old. None of them spoke English, so our presentation was being interpreted by a worker at the center. As I looked around the room, it became clear that I was more nervous about meeting them than they were about meeting me. They laughed, joked, and whispered to each other. Some paid attention, some didn't. Some were confident and asked questions, and some were timid and sat quietly. They weren't mad at me or afraid of me; they were just normal teenage boys.

What I learned from my experience working with this group of teenage refugees is that they, despite their circumstances, are regular teenagers. Nothing about the refugee process suddenly makes them dangerous or angry. And, for many of them, they are here not by choice, but they are fleeing persecution or danger at home. It became clear that what we constantly hear on TV is a distortion of reality. It does not reflect the truth of who these refugees are as people and why they have decided to make the treacherous journey to America. It is easy to for people of TV to talk about refugees in the third person but having gotten to know some of these kids on a personal level, it makes it impossible to believe the pundits. My experience with SLP has taught me to look past the definition of what makes a patient a part of a vulnerable population, whether they are a refugee, homeless, or a victim of domestic violence. No matter what their label is, they are first and foremost human, and for the vast majority of them, they did not choose this path. So, as a future physician, it is our duty to look past the labels and enter every encounter with an open heart and open mind. No matter the situation or the label given to our patients, we cannot let perceived differences get in the way of helping people in need.

Joshua Muñiz

2015-2016 M2 Scholar





intimate partner
violence (ipv)

Being a Physician

I often find myself reflecting on what it means to be a physician. My interest in medicine and becoming a physician began long before medical school, when I was trying to decide on a career path and continues to be an ongoing process of evaluation even now. As I have progressed through my medical education and I have gained more clinical experience and greater insight into medicine, I found that my opinions on what it means to be a doctor have slowly evolved. My experiences through the Patient-centered Medicine Scholars Program's Service Learning Program have afforded me a unique relationship with a vulnerable population that has significantly helped shape my current thinking.

Our domestic violence service learning group first met last September, and we were each assigned a client to work with. We broke off into pairs in order to get to know our clients better. Before we got started, I was nervous for many reasons; one of which was that my client primarily spoke Spanish, and my Spanish was shaky at best. I was apprehensive that she would ask me about things that I didn't know or couldn't help her with, or that I would react to her story in a way that made her uncomfortable. As I began speaking with my client, a story of horrific events slowly unfolded. The stories that she told me of being hit and beaten unconscious were shocking even with the possibility that some of the intricacies were lost in translation. My focus completely shifted. My feelings of apprehension had completely given way to shock and hurt that I felt for her and her children. I was amazed at her strength and calm while recollecting such traumatic experiences.

For our next meeting, I accompanied her to a physical therapy appointment to evaluate back pain that she had briefly mentioned in our first meeting. Before we started, she shared more details about how she had been shuffled from one specialist to another in hopes for some relief, never getting solid answers or definitive next steps. As she worked through her appointment, I watched her wince in pain as she tried her best to perform the tasks asked of her but noticed that she never complained and never asked to stop. Before leaving, the therapist elaborated on her complicated injury, and it became very evident that her pain was much worse than it appeared at first glance. I left the appointment with a mix of emotions: feelings of inspiration from her resilience, but also feelings of frustration for her. Her health care providers were not guiding her to get the care she so badly needed. Somehow this brave, beautiful, strong woman was being overlooked and brushed aside.

This experience and many others this year added to my reflections of what being a physician means to me. For me, being a physician isn't about knowing all the biochemical pathways, every drug mechanism of action, or having all the answers right away. Being a physician is about listening. It's about listening with your ears and also with your heart. It's about taking the time to see each patient as a whole person. It's about understanding what unique, dynamic factors make your patients who they are. It's about guiding your patients through an often confusing medical world. It's about partnering with your patients to find them the best possible solutions. Being a physician is about caring for your patients.

Jessica George

2012-2013 M2 Scholar



Home Sweet Home

Home is where the heart is. It is a place of solace and relaxation. It is a haven for us at the end of a long day or a stressful week. How would it feel if this sacred place became your most feared? Where you were terrorized daily? Where you petrified at the thought of what was awaiting you upon your return? That is the reality for many women (and men) that are victims of domestic abuse.

I choose this concentration group mostly to feed my own curiosity. It seemed as though the topic of domestic violence was quite pervasive in our culture and yet it was not something that I had encountered firsthand. My choice to continue pursuing PCM was made quite easy when I realized I had the remainder of my professional career to hone and cultivate my clinical skills. Juxtaposed with this was the finite time in which I could expose myself to so many of the vulnerable populations that exist.

The greatest lesson I learned was that, much like hypertension, domestic violence is a silent killer. Women live and die at the hands of these men who at one point promised them the world. We are so quick to point fingers and assign blame to a weak woman, one who probably deserves it, one that is too stupid to walk away.

She is in fact the most adept person you have ever met. She has had to learn how to navigate a situation in which every day, every moment her life is in danger. She has learned how to survive without the resources that she needs and deserves. She has gained an ability to function in a suboptimal environment and often is doing so with children. She has calculated how to keep her attacker at bay to protect her children as best she can. She is a warrior with a battle plan that she executes each and every day.

The best we can do is educate ourselves about domestic violence. Not only as future health professionals but also as friends, siblings, parents, cousins, and co-workers. The more social support we can provide the more we empower these individuals to see that they are victims that will be protected from their persecutor. They will be supported by their friends and communities who will stand up against what is wrong—not make them feel at fault or to blame.

This opened my eyes to the unique experience that each and every patient will bring in the door. It reminded me that I am the expert on a very small domain but that the patient is an expert on his or her life. By fostering a relationship that is built upon trust and respect, a physician can evolve from being simply a health care provider to an advocate, a resource, and essentially a conduit that connects people to a healthier life and state of well-being.

Shama Patel

2012-2013 M2 Scholar

Nothing Else to Lose

While in medical school, we spend a lot of time learning how to collect information from a patient. It's imperative we know how to ask for a history and how to write out information in a concise way that makes sense to someone who has never met the patient. The reality is, her story is not concise. It's complicated and personal. It's heartbreaking and it's inspiring. I had the privilege of hearing her story. M was in an abusive relationship for several years before leaving and was still experiencing physical manifestations of the abuse. The constant headaches and back pain were things that concerned her, yet she became used to living with it.

One domestic violence topic I have become increasingly interested in this past year is the idea of why women stay. It's a question that everyone wants to know the answer to. We don't want to appear ignorant about this issue, yet blame is often placed on the women for not leaving immediately. Victims recognize that it's dangerous to leave an abuser. Over 70% of domestic violence murders happen after the victim has left a relationship because the offender has nothing else to lose.

M didn't know much English. She didn't have a job at the time and had little support from her family. But what she did have was her son. All of her decisions and thoughts were centered around what would benefit him. Even though our conversations were initially focused on information about her health needs, she spent the majority of the time talking about him - her light, joy, and reason for living.

After sharing her story, she confessed that she believed herself to be an ugly and weak person. Still, she was finally able to leave. She broke the silence; she is now rebuilding a happy life for her and her son. She may be the strongest person I know.

Sabrina Reed

2012-2013 M2 Scholar



Reflections

My experience in the Patient-centered Medicine (PCM) Scholars Program this year has shown me the importance of the Service Learning Program, especially for future physicians who themselves, surprisingly or not surprisingly, hold on to stereotypical beliefs about who victims of domestic violence are and what they should look like. As educated as we are, there is still so much more to learn – things that simply cannot be taught in class.

I listened intently as my client shared her story of abuse with me through her tears. I rubbed her back during her pauses and felt myself become more emotional. Her children also witnessed the abuse her husband inflicted on her – she said she had to leave him for her children's sake. She shared with me that her teenage son wanted to become a doctor so that he would be able to cure her of her aches and pains. Aches and pains that were the result of her years of abuse. Aches and pains that physicians might never connect to her history of physical abuse. Throughout her story she repeatedly asked if I would be able to help her.

Visiting a shelter for women and their children who were survivors of domestic violence left me constantly wondering how much domestic violence had impacted the children's lives and in what ways that exposure will manifest itself as they get older. Will these children become the: caretaker, confidant, assistant, overachiever, referee, or the scapegoat within their family? Will they one day become abusers themselves? Will they become victims again of this cycle of violence?

Overall, I am appreciative of my experience with the women, children, and my concentration leader. I witnessed strength, resilience, and determination. I learned the importance of subtle warning signs and the need for everyone to become more aware of this all too common but silent phenomenon. Domestic violence should be discussed often, and preventative measures need to be put in place to eliminate this horrific abuse. As future physicians, we need to educate ourselves in order to better advocate for and protect our patients.

Jacqueline A. Wulu
2012-2013 M2 Scholar



We began our project with the Service Learning Program (SLP) by working with victims of domestic violence at the Greenhouse shelter. We wanted our interaction to be an active one, one that the women could take with them. We decided that yoga would be an ideal tool to help them relax, deal with physical pain, and find a sense of peace. We bought mats, rented a yoga video, and headed in the direction of the shelter. We drove past the unassuming green-shuttered shelter three times before arriving at the unmarked front door, already slightly daunted by the task ahead.

Entering the shelter on the first day, we would have been hard-pressed to describe our expectations. Personally, I saw a version of the yoga classes I'd previously attended but with a somewhat less enthusiastic crowd. What we didn't expect were all the kids. As we were laying out our mats in the second floor common room, we were suddenly surrounded by children chatting excitedly about yoga. We were a little put off at first - this was definitely not the peace-seeking sort of environment we had planned. But as the yoga session went on and the kids really took to the various poses, we realized that we had stumbled on something uniquely valuable - a group activity for family health, happiness, and well-being.

Before Greenhouse, I'm not sure what I thought of when I imagined a child survivor of domestic violence. A lack of eye contact, perhaps. Shyness surely. Some obvious sign of pain. The rambunctious crowd we encountered on that first day quickly dissolved any preconceptions I had. One little girl, braids swinging, ran into the room and wrapped her surprisingly strong arms around my waist. "Yoga!" she squealed in excitement, then quickly let go of the embrace to greet the other SLP students in the room. Her enthusiasm was tangible, and it shook me out of my academic stupor, like a bright winter morning after an early dusk.

Later, in a rare quiet moment during downward dog, we all heard a small eruption. My infamous hugger quickly collapsed into a pile of giggles. "I farted!" she announced when she had the breath. Our concentration leader, who was leading the session, graciously explained how yoga can do that, how it can get our tummies a-movin'. As for the rest of us, we were on the ground with the kids rolling with laughter, all stress thoroughly vanquished.

As we left that evening, one of my SLP colleagues turned to me and said, "I can't remember the last time I laughed like that." I realized that she was absolutely right - it had been a good long while since I'd really laughed. Our evening had been full of pure, light-hearted comedy, without sarcasm or pessimism or degradation. We had laughed from the inside out and we all felt so much lighter for it.

So with my time at Greenhouse I learned three things. First, that when things don't go according to plan, they can actually birth something more valuable and more beautiful. Second, that domestic violence doesn't necessarily look like you'd expect it to - there aren't always bruises, cuts, or tears. And finally, I



learned about the power of a child. Even when everything in the world is trying to steal their happiness, they can find joy for themselves. And more - they can find some extra joy to give to you.

Nikita Vashi

2012-2013 M2 Scholar



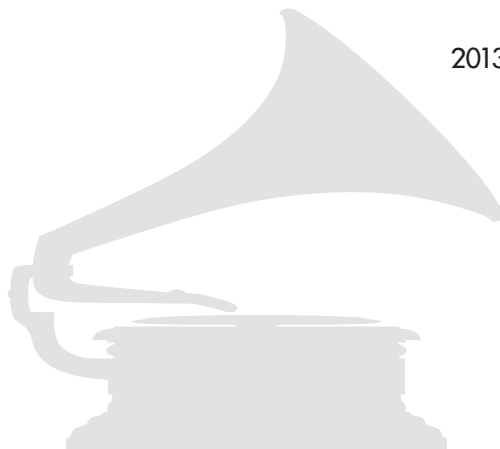
"I am 22 years old and I arrived at the shelter in November. Since then, I have struggled with depression, anxiety, and headaches. I arrived in the United States two months ago after meeting a man on the Internet who offered to help me come over from Honduras with my 4-year-old daughter. I had been talking to him online for months and he seemed nice. I really wanted to come to the US so that my daughter could have a better future. When I got to the US, I found out he was involved with sex trafficking. The man was very abusive, and I only managed to leave him when my daughter and I escaped out of an open window and went to an aunt's house. I had been a sex slave for two months. I am now concerned that the man may have sexually abused my daughter when he was alone with her because she has been very anxious lately and cries more than usual. I know the man is looking for me because he has already had my uncle killed back in Honduras."

I met this patient two days after she arrived at the shelter. She wanted to see a doctor because she had been experiencing severe headaches and because she was concerned about her daughter. She had some trouble telling her story because of the immense emotional pain that it evoked, but she liked the feeling of being listened to. After hearing what she experienced, I was in a state of shock. I knew that sex trafficking existed, but I had never seen it up close and it was truly horrifying. I felt powerless to help her and I wanted so badly to take away her pain and to bring the person who did this to her to justice. It was clear to me that it was not the physical abuse that she was struggling with, but the feelings evoked by being stripped of her humanity that were difficult to cope with. She had been completely dehumanized and now she had to learn how to live and care for her daughter with no resources in a country in which she does not speak the native language. My heart actually hurt for this strong and courageous young woman.

Volunteering at the domestic violence shelter was incredibly valuable for me. I broke away from my books once a week to talk to women and children who have experienced unbelievable adversity and come out on the other side with immense courage and strength. I had the privilege of practicing yoga with the women and seeing them let go of fear, stress, and pain for one hour every week and I can honestly say that I benefited from the experience at least as much as they did.

Jennifer Cueto

2013-2014 M2 Scholar



Silent Heroes

During my wellness visit at the shelter, I met a woman whom I call Luz. Luz means “light” in Spanish. Although that is not her real name, the name seemed appropriate for the incredibly strong and light-hearted woman that was in front of me. Luz was interested in the wellness visit because she had been having headaches and insomnia since she arrived at the shelter with her children almost 3 months ago. She indicates it had been difficult to sleep when she is constantly paying attention to new sounds, voices, and noises. She feels like her mind races and she thinks a lot about her current situation and the wellbeing of her children. As a result, she feels tired throughout the day but cannot fall asleep. She indicates that before she came into the shelter, she was so stressed that she had no time to think about herself and her health, but now that she feels safe and comfortable, she has more time to reflect.

As I discuss her past medical history and symptoms associated with her headache, I learn that Luz was repeatedly hit on the head multiple times. At times, she even lost consciousness, but she never sought medical care. I am in shock as to how and why someone could ever hurt Luz and how her body has stored the memory of the physical pain she endured for years. It is as if her body will speak of the violence that it witnessed, even when nobody else voices it.

I also learn about Luz’s life at the shelter. She interacts extensively with other women and families living there and spends precious family moments with her children there. She proudly admits that her teenage son is learning to cook even better than some of her friends. They cannot always decide what they will eat, since cooking duties rotate, and meals are shared among the residents there. As a result, it is difficult for her to agree to a specific diet or meal plan, but she does agree that she will drink more water and will take a multivitamin more regularly.

When I ask her about her hobbies, Luz has difficulty thinking about them at first, for she is not used to thinking about what she likes to do. After a while, she indicates she loves to garden, to feel her hands on the earth and take care of plants. Because the plants and the garden she used to have are no longer available to her, she instead occupies her hands, and mind, with chores around the shelter. This showed me that when Luz left her home, she did not just leave a physical address. She left a place full of memories, both good and bad, and a place that she once called her own. As her time in the shelter is soon to be complete, she is constantly reminded of the transient nature of her stay at the shelter.

As we continue our talk, I ask Luz how she is feeling. With a big smile on her face, she indicates she feels happy and content. She is happiest when her children are joyful and well. Throughout our short conversation, Luz has shown happiness even in the midst of the anxiety that comes with living in a transient living situation, and despite living through many hardships. Luz emphasizes the importance of family and love in keeping her connected.

In hindsight, I’m not sure what I was expecting as a result of my first wellness visit at the shelter. I felt unsure as to how I could help, if at all. Who would

have known that on the other side of that door would be a woman full of inner strength, overwhelming resilience, and humor.

So I leave this experience paradoxically hopeful. Yes; violence is unfair, wrong and unfortunately very real. But the strength of the human spirit is very real and there are silent heroes walking around us, with stories of survival against violence and of victories won. As future health providers, we will get to be active participants in this battle. With our actions, our words, and our presence, we get to support our patients on their road to wellbeing and hopefully help tilt the balance towards a healthier, more peaceful world.

Ana Mauro

2013-2014 M2 Scholar

IPV



Harmony

Harmony can be defined as a pleasing arrangement of parts that are balanced and beautiful to hear. For that reason, and many more, I have chosen to refer to my patient as Harmony.

I remember sitting down with Harmony for her wellness visit at the shelter. During her visit she spoke with such strength and conviction, "This is was not what I had wanted for my life." Harmony told me how she had witnessed her mother's struggles with domestic violence. Specifically, how these experiences had left her mother hard and broken. It was in those moments that Harmony realized she wanted more for her life. She wanted to live a life free of violence and terror, a life filled with peace and love. However, almost fifteen years later, Harmony is now a mother of three and a domestic violence survivor herself.

Unfortunately, Harmony's story is not unlike that of other survivor stories I witnessed while at the shelter. Prior to joining the Service Learning Program of the Patient-centered Medicine (PCM) Scholars Program, I had known of the statistics behind domestic violence, but I had never intellectualized how cyclical of a pattern domestic violence truly is. Harmony described domestic violence as a world which one tries so desperately to escape. It is a daily battle that takes a lot of strength and perseverance, but she finds the strength to keep fighting in her children. It was in that moment that I realized all I could do for Harmony was to be present and pay respect to her story and struggles.

Yes, Harmony is a survivor of domestic violence, but she is also so much more. She has not let these experiences strip her of her inner peace. Harmony is a beautiful composition of many experiences, some beautiful and some more difficult to bear. Following Harmony's wellness visit, I was able to spend time with Harmony and her three daughters and realized that her desires had come true; in that moment she was living a life full of love and joy.

Cynthia Orantes

2013-2014 M2 Scholar

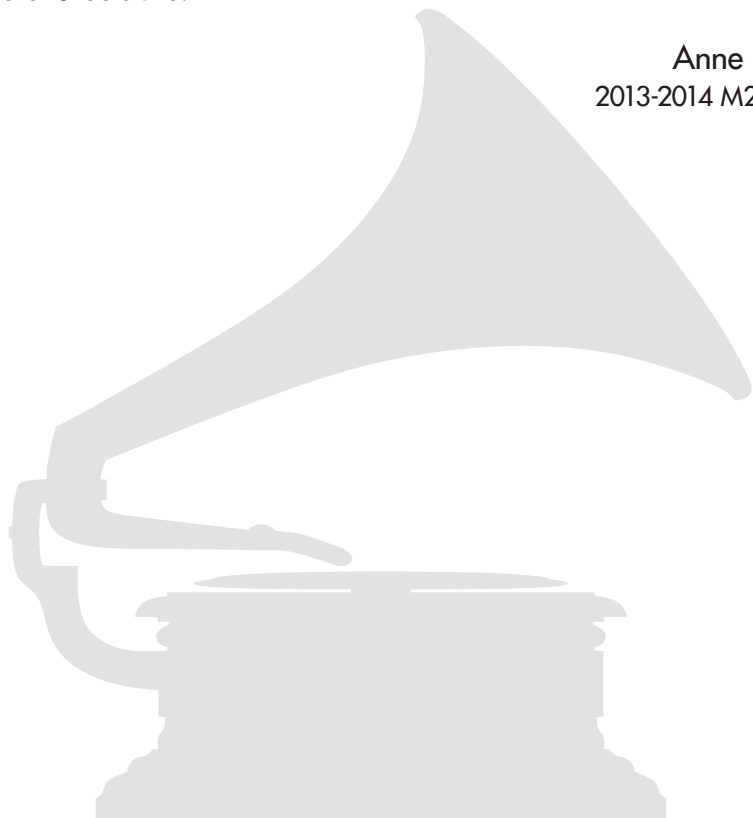


I volunteered to lead a yoga session at the shelter that night. I was the only group member available that evening, so I showed up and set up some mats. At first, none of the ladies at the shelter came and I was a little discouraged. I was about to pack up, when one of the residents of the shelter walked in. Excited to have a participant, I chirpily asked her "how are you?" She replied, "not so good." I was surprised by this stranger's honesty with me. I was accustomed to getting a bland, affirmative response, but if that's what I expect, then why bother asking? Since it was just the two of us, we chatted for a little while and she told me about herself and her family.

She had been at the shelter for a little while with her school-aged kids. Because the shelter tries to help as many families as they can, women and their families are only able to stay a short amount of time, and her time at the shelter was coming to an end. She hadn't figured out where she was going next, and she was nervous about the future. I didn't know what I could do or say at that point. So, I just listened and then we did some yoga.

At the end of our time together, I realized I would probably never see this woman again. I wished her well and said that I hoped everything would work out for her and her family. She turned back to me and said "Don't worry. Everything will be ok." Again, this very strong woman had surprised me. Her instinct to comfort me, this stranger who was trying to help her, and her strength in such a terrible situation, communicated a sense of resilience that I don't know if I'll ever understand.

Anne Henson
2013-2014 M2 Scholar



The Drive to Serve

I've always envisioned myself practicing patient-centered medicine, even if I didn't know it by that name. To me, that was what being a doctor was about – helping people get better and stay better – but also building lifelong relationships. As I've gone through medical school, I understand just how difficult that can be, given time, space, and financial constraints among other things.

Even more than those things, the lack of time, stress, and pressure I've placed on myself in medical school had put me on a path to follow in the footsteps of the many doctors who go into medicine for the right reasons but end up practicing for the wrong ones. Even joining a program like this, one devoted to serving those who are most vulnerable, I came in for the wrong reasons. Sure, I wanted to help people – but I wanted to work with domestic violence survivors, I wanted to spend my clinical time giving back, I wanted to make a difference.

And you may be thinking to yourself, how are these bad things? Inherently, they may not be, but I was viewing my work with these women from the wrong perspective. This work was never about me – it shouldn't be about me. For as much experience as I have in the field and as much personal connection as I have with this issue, this was not my story. I was just a tiny part of the program by which these women could propel their lives forward.

Each of these women has been through so much, not only in their abusive relationships, but also ever since then. The decision to leave was not likely an easy one, nor was the escape. But now, in a position where they need to rebuild their lives, I could not be thinking about myself. We take for granted the things we have and the experiences we never have, but by the end of this program, by having the privilege to be at the service of these women, I have once again aligned myself on the path to be of service to others, rather than unintentionally being of service to myself.

Michael A. Belmonte

2014-2015 M2 Scholar



This year we were placed in concentration groups. I was given the opportunity to work with ladies that have undergone domestic violence. It was very interesting to learn about their experiences and how they are overcoming the adversities. This experience has made me more aware of the signs of domestic violence when you see patients in your clinic.

We did wellness visits every Friday and did a presentation on health-related topics that the ladies were interested to hear about once or twice a month. Twice a month Friday during evening we did Yoga to teach the ladies techniques that can help them to deal with stress and relax. I have never done Yoga before so that was a great experience and Dr. O is good at teaching yoga. I loved working with Dr. O. The way she speaks and her calm and warm presence makes patients feel welcome and be open to speak about anything that we ask when taking history. Her Spanish is also extraordinary. I hope that I can get the opportunity to work with her in the future.

Finally, I just want to say thank you for the opportunity and all the effort that has been placed in this program.

Fatima Giron

2014-2015 M2 Scholar



On Confidence and Learning

I had practiced on a laughably fake arm, as well as on my fellow students. When it came time for me to first draw blood from a patient, I thought I was ready. Everything was going as planned: the vein was found, tourniquet tied, alcohol swabbed, and flash of blood seen. I began filling the tubes, when I realized the flow had slowed. No problem. Adjusting the needle slightly, I repositioned its angle of entrance. To my complete horror, the needle came out of the patient's arm mid-adjustment, and what seemed like rivers of blood poured forth from the puncture site. In a flurry of frazzled panic, I removed the tourniquet and dove for a pile of gauze. I felt like an abject failure holding all the bloody gauze, stammering incoherently to my stunned patient.

In the following weeks, memory of the gory incident left me disappointed and anxious about my next draw—but the show had to go on. Building up my optimism, I took a confident, clean-slate stance toward my next attempt. First try, I missed the vein. I apologized to the patient and told him that I might not be able to hit it. “No, you’ll get it,” he said. Sure enough, I was successful on my next try. It took me months to become a consistent phlebotomist, but the whole experience (including the wise words of the aforementioned patient) taught me the value of confidence and composure in a stressful situation. Furthermore, I realized that I should never let one negative incident affect my self-assuredness, as fixating on a failure is certainly not conducive to progress.

Indeed, the first time I watched my PCM preceptor excise a skin lesion, I marveled at the precision with which he cut a near perfect circle around the blemish with his scalpel. Having cut through the many layers of epidermis and fascia only on a cadaver, I was—a bit obtusely—surprised when bright red blood perfused the wounded area. With practiced automaticity and a calm demeanor, my preceptor then proceeded to put three perfectly aligned stitches where the perturbation once existed, and as quickly as it had come, the blood retreated. The whole procedure could not have taken more than about five minutes, and while I was obviously aware of stitches as a medical concept to close a wound, there was a dazzling simplicity to the process. That parts of the human body can be stitched and fixed just like a rip in a piece of cloth by a knowing, confident physician is an elegant truth, and one that I was delighted to appreciate.

Yuli Zhu

2015-2016 M2 Scholar

Participating in the Patient-centered Medicine Scholars Service Learning Program shaped my M2 year. Through the program, I had the opportunity to work with other UIC medical students and our wonderful preceptor, Dr. O, at a Chicago area domestic violence shelter for women and children.

During my first visit to the shelter, I was able to meet one-on-one with one of the ladies at the shelter. I was slightly nervous as it was my first known encounter with a domestic violence survivor, and I was not entirely sure how to start the conversation. I was afraid that I might ask an intrusive question or that it would prove to be too emotionally challenging. However, as the year went by and I spent more time at the shelter, I realized that the most important thing I could do for the women was to be present and listen to their concerns. I tried to help them navigate their difficult situations and offer some advice, but mostly I just listened. I moved away from the feeling that I must structure the conversation in a certain way and instead let the women lead the conversation. Although through these brief conversations I was only able to get a glimpse of the struggles and sacrifices that these women have made, I was keenly aware during every conversation of their resilience and strength.

The women's willingness to trust me and open up did not go unnoticed by me. I am appreciative of the time that the women took to meet with me and for the opportunity they gave me to learn more about their situations. I hope that during my medical school education and beyond that I will be able to continue to work with and learn from vulnerable populations, including domestic violence survivors.

Polly Godfrey
2014-2015 M2 Scholar



I could write pages about my experiences this year and how they have shaped me as a medical student and will continue to mold me as I continue my training through school and residency. But all those pages boil down to two sentences:

Individuals who experience domestic violence need three things from their doctor: an understanding mind, an empathetic heart, and a space of silence in the conversation. All further thought and action stems from this place of mutual trust and respect.

In order to be a good doctor, I must first strive to be a better human.

Tara Bylsma

2015-2016 M2 Scholar



Victims and Survivors of DV

Victims of domestic violence. I was told I would be working with victims of domestic violence. When I heard that phrase, I subconsciously began to picture the people I expected to see. Wounded, weak, women who work to find the will to go on. And yet, when I met these women, I was shocked by their strength and selflessness. When they had the chance to ask questions of the medical students, they asked not about themselves but about their children, their brothers and sisters, and their mother and fathers. This response may partly be attributed to the fact that many of them had spent years undermining their own needs, either in order to put their children first or in response to someone telling them that their needs are insignificant. However, I think it also speaks to their altruistic nature and their enduring capacity to feel such love for their family even after the trauma they experienced. Of course, it is important to note that these women are not all the same, but I was amazed to see these qualities in the majority of women I met at Greenhouse Shelter. None of these women fit my image of "victims".

And yet, on the other side of the spectrum, the term "survivor of domestic violence" has its own downfalls. Survivors are expected to be warriors, to be strong and independent. Being a survivor suggests that the trauma is all in the past, that one has triumphed over his/her situation and come out on the other side. However, the struggle doesn't end when one leaves his/her abuser. It is a continuous fight to support oneself and one's children, to be positive and hopeful, and to stay safe and healthy. Domestic violence can cause lasting physical, emotional, financial, and even spiritual damage. If we make the mistake to assume that the fight is over when the victim is physically distant from the abuser, we may miss the opportunity to provide help when our help could be of use.

So what should we term people who have experienced domestic violence? I think it might be useful to say just that: "people who have experience domestic violence". After all, they are people first, and their experience with domestic violence is a qualifier, not an identity. I understand that it may not roll off the tongue as easily, and so "victims" and "survivors" will probably remain the preferred terms. However, I think it is important that we all recognize the power of these words and do our best not to let it affect our perception of the men and women who experience domestic violence.

Rachael Tatz

2015-2016 M2 Scholar

Empathy

A flurry of hands gesticulates to another expectant pair, as a telegraph operator awaits a message delivered through underground wires. Through shared space, joy, pain, two women share stories voiced and untold, spoken and unheard.

The pair sit across a speckled plastic table, swaddling their babies in the crook of an arm clothed in vibrant African print. Sitting between them is a medical student of vastly different experiences. Greetings and introductions are in order, performed with equal doses of difficulty and bemusement through language and cultural barriers. The barrier itself is thick but porous.

We tell our thoughts through crisp though untested English, mellifluous though rusty, cobwebbed French, and a cobbled-together tongue of expressions and motion. Ideas flutter back and forth between these three people brought together by chance, if only for a moment. They consist of stories from Ethiopia and Congo, hardships endured and harrowing journeys to this loving space, brainstorm on health-promoting behaviors, antioxidant foods and nutritious meals, making sure that their kids get their shots; love, life, and compassion.

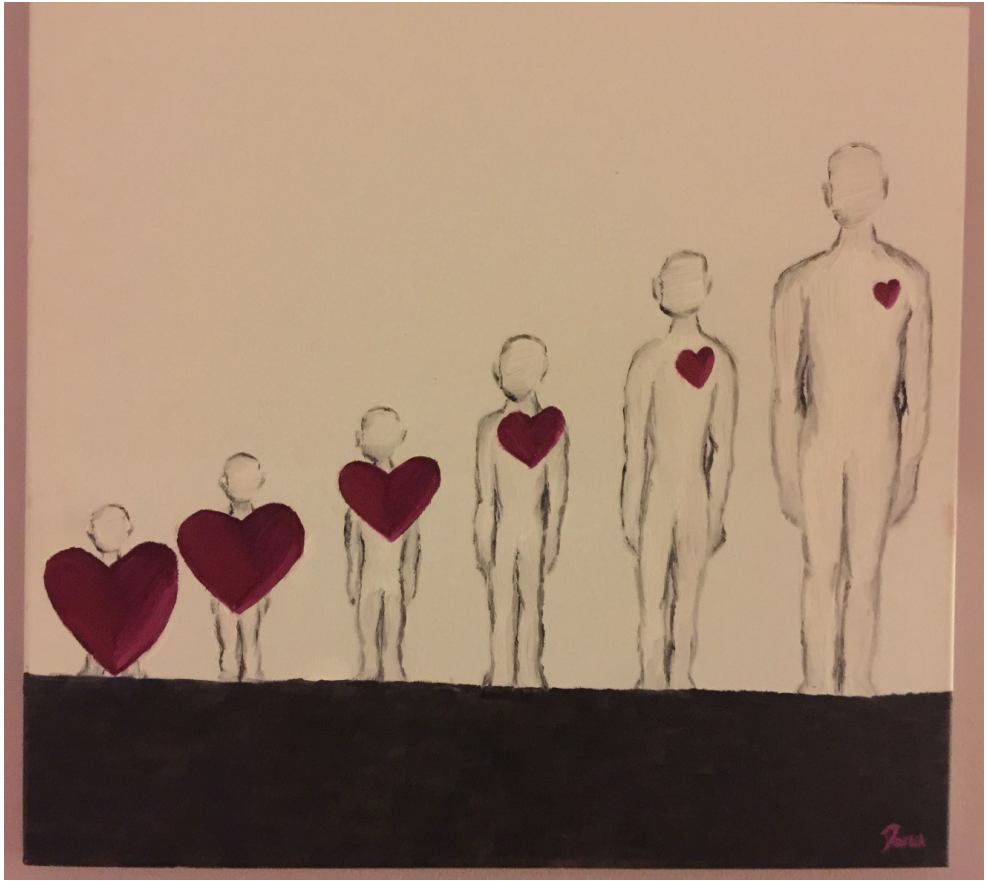
Between the two women, perfect strangers until a couple days ago, burns a spark too bright to be snuffed out by callous hearts and cruel hands. Hailing from opposite sides of a continent across the sea, their respective spoken languages, cultures, and religions are not easily shared. A more fundamental flame, one rooted in love and strength, fires their easy trust in each other. Stories flow like water even as voices struggle to be heard; they carry forth tears shed, and embraces given and good yoga positions for back pain and ideas for heart-healthy meals.

The medical student sits quietly, interjecting with gentle suggestions here, distracting raucous but distractible children there, and learns what true empathy is, how hard won it is, and how precious it is. Aspiring to it is the noblest task of a physician, caregiver, and fellow

Takahiro Yamaguchi
2015-2016 M2 Scholar



Bring Love Back



As physicians we play a role in not just the physical aspect, but also the very personal well-being of every patient. This year has not only taught me how to be compassionate, but how to break society's cycle. We live in a harsh, competitive, selfish time. A time where the focus is on me, me, me. A time where you are working for yourself. A time where you place yourself first. Studying to be in the field of medicine does not help with that either. You find yourself constantly placing your needs before others- to be better, to do better, to be at the best place you can be. It is not until you open your heart and realize that helping and loving others is the only way you can be better, do better, and be at the best place you can be. So I ask that every physician take it upon themselves to reverse this societal mentality, and help not only the health, but also the hearts of our patients to grow.

Dana Yousef Darwish
2016-2017 M2 Scholar

ipv

Working with Dr. O, my PCM preceptor and the ladies from Greenhouse Shelter was an incredibly rewarding experience. I cannot emphasize enough how much I learned from these women. Even after having gone through the incredibly difficult journey of leaving their abuser, they were still very eager to learn. They wanted to know more about their own health, specifically women's health. They were very open to the idea of trying out mindfulness and meditation as a way to cope with their stress. They all wanted to be empowered.

Through the IPV SLP concentration we were able to fulfil a tiny portion of that empowerment through educational workshops. The moment that stands out in my mind the most is how at peace the women were after a short meditation session I led for them. For many of the women, it was the first time that they had a small amount of time dedicated just to themselves without having to worry about caring for their children. At the beginning of the session, several of the women looked a bit uneasy and tense. However, at the end of the session they were so much more relaxed that the difference was palpable. They felt such a difference themselves, that they assured us they were going to try the breathing techniques and short meditations on their own. Having the opportunity to offer something so simple yet impactful really turned my experience into one that is unforgettable.

Maria Gomez

2016-2017 M2 Scholar



When I first began the Domestic Violence (DV) Track of the PCM Scholars Program, I did not know what to expect out of the experience. Prior to visiting Greenhouse, we had the opportunity to have a dialogue with my PCM preceptor on DV and all the ramifications it has on the individual and every aspect of their life. Although this was a very eye opening and informative session, it made me really intimidated to visit the shelter for the first time. To say the least, domestic violence is very emotionally charged, and I did not know what to expect when I went to Greenhouse and met the ladies who had recently experienced these things. I was worried about saying something wrong or overstepping my bounds. However, after the first visit, my concerns quickly disappeared.

From the moment we began our presentation we were greeted with warmth, kindness, acceptance, and curiosity. The ladies were very thoughtful and genuinely interested in what we had to say. It was always such a pleasure to go and chat with the women about their concerns, goals, or simply their day. You could see that they truly appreciated our work and company. I thought that there would be this heaviness looming, but it was the exact opposite. It was great to see these strong women taking steps to better their future and those of their children. They were putting their past behind them and not allowing it to define them as an individual. It is this perseverance and strength that I take away from this year and will carry with me in years to come.

Beyond the special moments that I got to share with the ladies, I was also fortunate enough to work with an amazing group of intelligent, diverse, and inspiring women. Thank you to Dr. O for your beautiful spirit and compassion, I have been truly touched and inspired by you. For this entire experience, I will be forever grateful. Thank you to the Patient-centered Medicine Scholars Program for making it all possible.

Nohemi Herrera
2016-2017 M2 Scholar



Working with domestic violence survivors was truly life changing and incredibly humbling. The women at the shelter were from all walks of life, all carrying a heavy load on their shoulders that I wouldn't know of if I met them anywhere else. That was probably the first lesson I learned. Sadly, anyone can find themselves in the hands of someone who is fighting their own battles but hurting you along the way. There is no description of a domestic violence survivor, they look like you and me.

Before this program, I had seen flyers in public restrooms displaying the hotline number for intimate partner violence, but I didn't stop to think what life was like for someone after they make that call. Through the program, I learned that I need to have that number memorized and have my patients memorize it as well. That some of my patients will screen positive for abuse and that how I react and respond will play a big role in what happens to them next. As a future physician, it is my responsibility to not only provide my patients with resources after they share something so personal, but to listen and be understanding of their decisions.

Visiting the shelter exposed me to a new world that I didn't know existed. Mothers and their children face many challenges and changes that we don't. They are in a new place, far away from everything and everyone they know. They own only a few items they might have packed in the middle of the night and lay awake worrying about what each new day will bring. Their previous housing wasn't safe and they took a chance so now they are living in a shared house, unemployed, with anxiety and depression manifesting itself as headaches, fatigue, low appetite, anger, and loss of interest in what used to be their favorite things.

I learned that I shouldn't assume that my patients live in a house or apartment, and that a roof over your head such as a shelter, doesn't define it as a home. Some women at the shelter shared that they have missed doctor appointments because they didn't want to leave their children alone in a new place with strangers. Our group made it a purpose to emphasize the importance of self-care and how we need to take care of ourselves so we can better take care of others. That concept applies to all of us, it is important to take care of ourselves first before we can take care of others whether that be of our children or patients.

I walked into the shelter many times thinking that I was going there to teach the women about different health topics such as maintaining good mental health, healthy eating, reproductive health, and self-care, but the women there taught me much more. They taught me that it is critical that we really get to know our patients so we can make appropriate and realistic recommendations for better outcomes. To not get lost in the details of medicine and make sure my patients see me as a friend that they can trust with their most personal information. Above all, the experience reinforced my belief that the best physician is one who is compassionate and kind.

Elizabeth Ortiz

2016-2017 M2 Scholar

Remembering My Humanity

We all embark on the journey to become physicians with a goal of helping people, following our passion, fulfilling our destiny, impacting disparities and the medically underserved, or you just couldn't see yourself doing anything other than what your parents groomed you to become. Whatever the reason, the journey is tedious, unnerving, consuming, and sometimes seems impossible. And the drive to continue must be deeply rooted in your entire being.

The pressure that we put on ourselves as students to thrive and succeed in our classes and compete for limited coveted spots of excellence can sometimes cause us to lose focus on the reason, we decided to become physicians. We lose sight of our humanity, and we become pseudo-superhuman. Being involved in the Patient-centered Medicine Service Learning Program has allowed me to constantly check in with my initial desire to become a physician. It allows me to put the things that I am learning into perspective and realize my current and future impact in medicine. Working with women and children that have experienced intimate partner violence has given me additional skills to be more cognizant of other's realities which will be an incredible asset as a future physician.

This program allows me to continue to show compassion, tolerance, and understanding towards my patients and more importantly towards myself. The work that we have chosen to do can take small pieces of us if we let it. This is why we must strive to remember ourselves in order to take on the tremendous and precious task of caring for our patients.

Antoinette Price
2016-2017 M2 Scholar



Broadening Perspectives

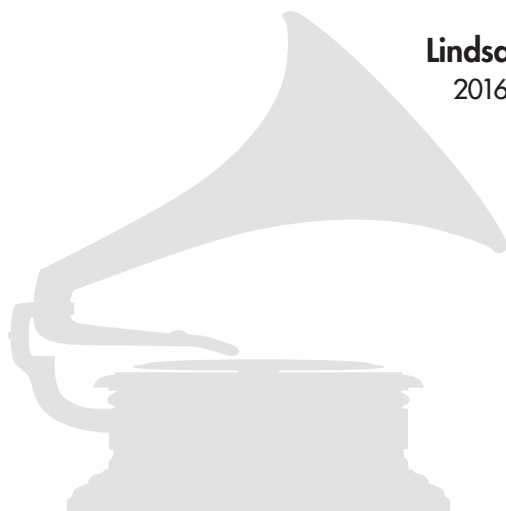
Our small group of women, mostly in their early 20s, wanted to know about menopause. The request came as a surprise – why is menopause even on the radar of someone in their 20s? My group of fellow medical students spent the week prepping our presentation and sat down at the kitchen table at the domestic violence shelter for women and children to talk about menopause. We began by talking about a normal menstrual cycle. Within only a few minutes of discussion, it became clear why the women, too young to be going through menopause, would want more information on the subject. Each of them had questions as to why their cycles had changed recently – were they going through menopause?

My brief experiences working with women and children at the domestic violence shelter opened my eyes to the complexities that personal stressors can have on a patient's health conditions. Other similar questions came up regarding insomnia, body aches and pains, as well as concerns about children wetting the bed and being hyperactive. Had a woman presented with changes in her menstrual cycle prior to this experience, I may have never considered domestic violence, or recent homelessness, as part of the differential. This is especially true given the resilience of the women and children at the shelter, as we continued to laugh, chat, and enjoy each other's company despite the complications in their lives.

Each new question and concern further highlighted the reality that clinical medicine and public health must go hand in hand. While some issues had pathologic origins, some were due to stress, a history of abuse, and socioeconomic insecurity. To only address the specific chief complaint without the underlying realities of people's lives would miss the mark of comprehensive care. Yet also, to only consider someone as a domestic violence victim, or homeless person, would be limiting in a similar fashion. This experience challenged me to simultaneously broaden my perspective when working with patients, without limiting their entire life and identity to one facet of their lives.

Lindsay Waggerman

2016-2017 M2 Scholar



PCM VOICES

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