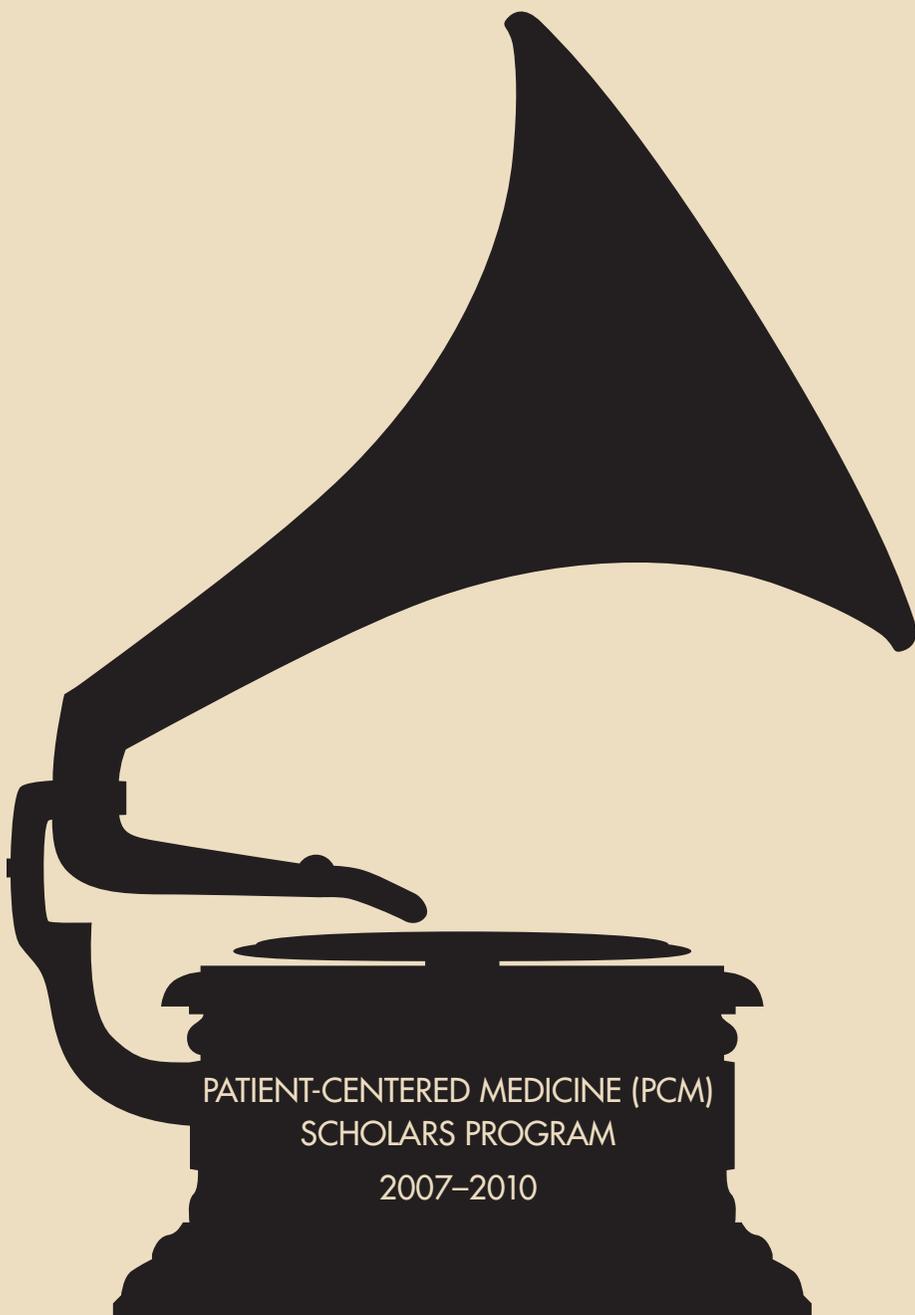


PCM VOICES

Reflections by M1 and M2 PCM Scholars



PATIENT-CENTERED MEDICINE (PCM)
SCHOLARS PROGRAM

2007-2010

Note: *The views expressed in this publication do not necessarily reflect the official policies and views of the Department of Health and Human Services or the United States government.*

This book was designed, printed, and bound by the UIC Office of Publications Services.

This inaugural issue of PCM Voices is dedicated to all the patients who worked with and contributed to the learning of PCM Scholars.



Foreword	1
Acknowledgements	3

M1 PCM Scholar Reflections

MUSINGS ON BECOMING A PHYSICIAN

Sumant Tumuluru	13
Ben Goold	15
Gurvinder Bhardwaj	17
Janet Cruz	18
Greg Podolej	19
Laurine Tiema	21

INSIGHTS ON PATIENT-CENTERED MEDICINE

Badewa Fatunde	25
David Kosoff	27
Kathleen Mendel	28
Rachel Guild	29
Brian Sindelar	31
Benjamin Carney	33
Ivana Brajkovic	35
Kajorn Kitiphongspattana	36
Dempsey Hughes	37
Luis Grau	38
M. Elisa Hernandez	39
Shari Vasquez	41
Nathan Stackhouse	43
Walter Kim	44
Tiffany Kim	46
Celeste Cruz	47

LEARNING FROM PATIENTS

Corey J. Thompson	51
Lindsay Martin	53
Samantha Knox	55
Meenadchi Chelvakumar	56
Anne Jennings	58
Angel Desai	60
Rashell Reynoso	61
Yesenia Valdez	62
Melissa Preyss	65

Mara Motley	66
Yury Parra	67
Mindy Guzman	68
Yulieth Vento	69
Anubhav Kapoor	70
Candice Kim	72
Michael Kurzer	73

REALIZATIONS

Tal Levin	77
Amish Desai	79
Richard Keyme	81
Olga Kantor	83
Julie Tsay	84

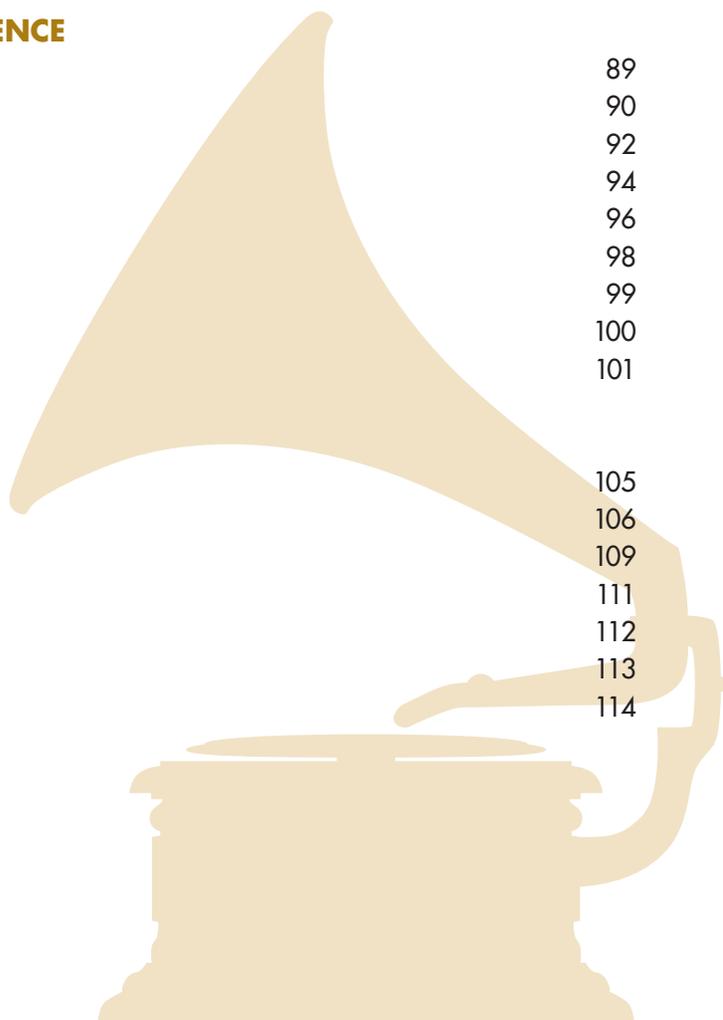
M2 PCM scholar reflections

DOMESTIC VIOLENCE

Bethany Schmidt	89
Krista Childress	90
Jennifer Lo	92
Laura A. Niiro	94
Esther Ji Yeon Lee	96
Geena Jester	98
Emily Newman	99
Peter Ureste	100
Lauren Kendall	101

HIV/AIDS

Jeffrey Larson	105
Nate Copeland	106
Ashley Styczynski	109
Blake Fleeman	111
Jamie Brewer	112
Lauren Taglia	113
Lindsay Martin	114

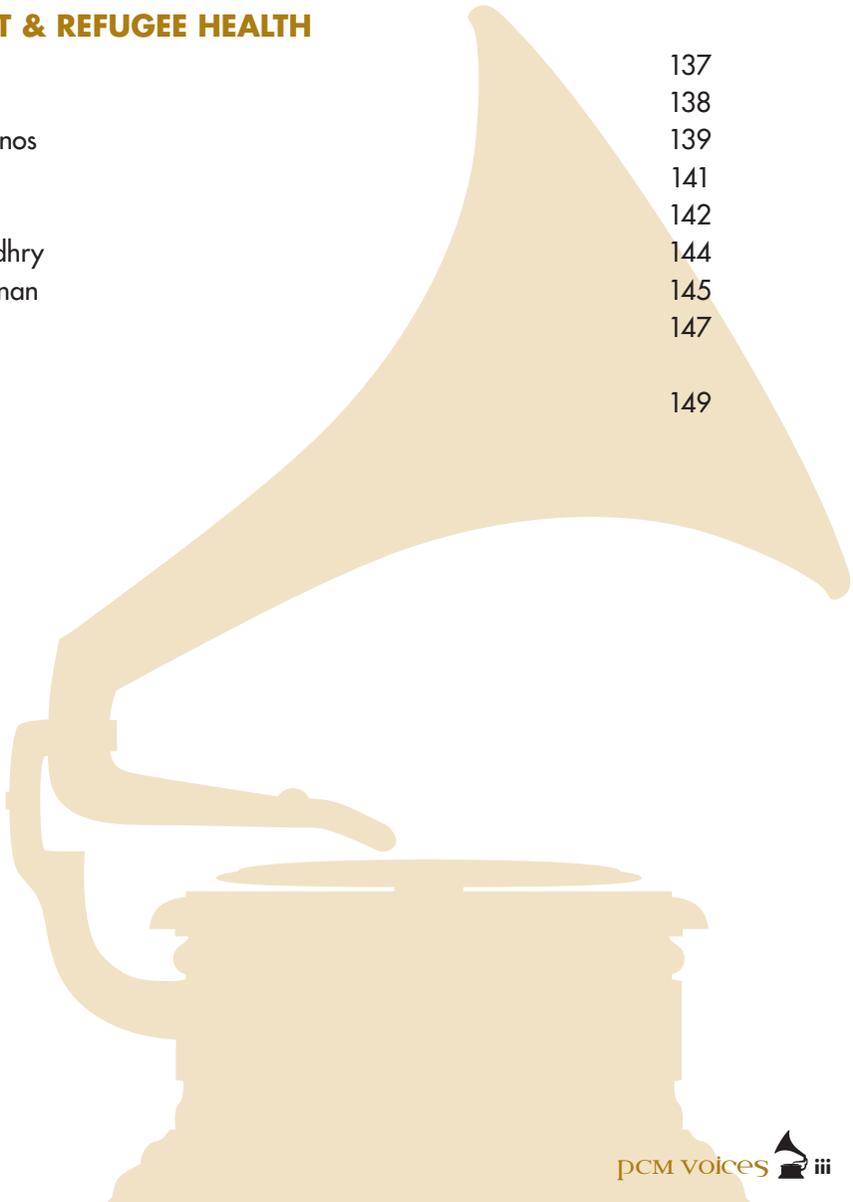


HOMELESSNESS

Poonam Merai	119
Lauren Herman	120
Alexandra Larson	121
Daniel Bunzol	122
Elizabeth Sokol	123
Kelley A. Williams	124
Ben Goold	126
Jade Pagkas-Bather	128
Daniel Yang	131
Greg Schweitz	133

IMMIGRANT & REFUGEE HEALTH

Lucy Vine	137
Jeremy Howe	138
Bianca Castellanos	139
Lisa Pearl	141
Rohan Shah	142
Samreen Choudhry	144
Mechu Narayanan	145
Amish Desai	147
PCM Scholars	149



Across the nation, there is rising concern and discussion regarding our health care system. Included in this discussion is the critical need for developing collaborative relationship-based models of care for patients and health care providers, a course of action that involves tailoring processes of care to be more “patient-centered” as opposed to provider-centered.

Empirically, there is growing evidence that patient-centered care—care that is respectful of and responsive to individual patient preferences, needs, and values—results in better health outcomes and satisfaction. Despite evidence supporting the benefits of a patient-centered approach, few medical schools have explicit curricula that focus on cultivating in learners the attitudes and competencies required for the teaching and practice of patient-centered care.

Since 2007, the University of Illinois at Chicago College of Medicine has developed and implemented a longitudinal curriculum, the “Patient-centered Medicine (PCM) Scholars Program”, which 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 underserved. The PCM Scholars Program includes a Service Learning Program that involves students in the direct care of underserved vulnerable patients in four concentration areas: domestic violence, HIV/AIDS, homelessness, and immigrant & refugee health. A fifth concentration in geriatrics is forthcoming. A central thread of the curriculum is students’ ongoing involvement with selected patients, including underserved patients, over the course of their training.

The learning experiences in the PCM Scholars Program are designed to make our future physicians think beyond the traditional medical education model of organ systems and diseases to understand the patient as whole person. This is certainly not an easy task for seasoned clinicians, let alone for beginning medical students.

This collection of reflections is the work of first and second year medical students, our future physicians, who participated in the PCM Scholars Program in the initial three years of the program.

These reflections should make us pause and rethink priorities for the teaching, learning and practice of medicine.

Memoona Hasnain
Director, PCM Scholars Program
Editor, PCM Voices

We are very grateful to all the students who contributed their writings for this publication. This unique educational endeavor by the Department of Family Medicine at the University of Illinois College of Medicine has resulted in a campus-community partnership, which is congruent with the mission of the College of Medicine and 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 faculty, the unwavering commitment of our community partners, and creates learning experiences that directly benefit patients, particularly those who are most in need of health care. We are thankful to the Health Resources and Services Administration for their generous support of this educational endeavor. Special thanks to all our preceptors, partnering community agencies, faculty, staff, students, and patients for their participation in the program.

Funding: The PCM Scholars Program is made possible [in part] by Grant # 1 D56 HP 08344 from the Health Resources and Services Administration (HRSA), United States Department of Health and Human Services, Bureau of Health Professions, Division of Medicine and Dentistry.

CORE PROGRAM FACULTY AND STAFF

MEMOONA HASNAIN, MD, MHPE, PHD

Director, PCM Scholars Program
Associate Professor and Director of Research

KAREN J. CONNELL, MS

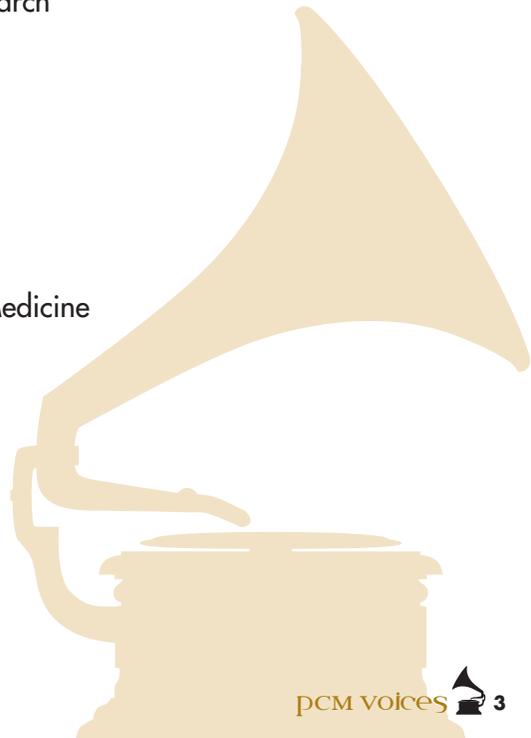
Co-Director, PCM Scholars Program
Research Assistant Professor
Director, Educational Development

DIANE M. KONDRATOWICZ, PHD

Coordinator, PCM Scholars Program
Instructor of Political Science in Family Medicine

EMILY PELA, MA

Coordinator, PCM Scholars Program



M1 COMPONENT: FOUNDATIONS OF PATIENT-CENTERED MEDICINE

University of Illinois at Chicago, Department of Family Medicine
Faculty Preceptors (2007–2010)

Maria Albright, MD
Marisela Dominguez, MD
Brian Dudkiewicz, MD
Tamarah Duperval, MD, MPH
Andrew Dykens, MD
Evelyn Figueroa, MD
David Freedman, MD, MPH
Michael Friedman, MD*
Emily Godfrey, MD, MPH
Samuel Grief, MD
Abbas Hyderi, MD, MPH
Nandini Khatkhatke, MD
James Lang, MD*
Marie McCarthy, MD*
Shreeketa Mehta, MD
Alicia Milan-Flanigan, MD*
Linda Morgan, MD, MPH
Elias Murciano, MD*
Adeyoyin (Lola) Okunade, MD
Sonia Oyola, MD
Mark Potter, MD
Nimmi Rajagopal, MD
Glenda Rios, MD
Jeffrey Rubin, MD
Eric Schackow, MD*
Nipa Shah, MD
Augustine Sohn, MD, MPH
Jeffrey Tiemstra, MD
Patrick Tranmer, MD, MPH

*Family Medicine, Saints Mary and Elizabeth Medical Center, Chicago.

M2 COMPONENT: SERVICE LEARNING PROGRAM

DOMESTIC VIOLENCE CONCENTRATION

Concentration Leader: Sonia Oyola, MD

Partnering community agencies

CONNECTIONS FOR ABUSED WOMEN AND THEIR CHILDREN (CAWC)

Antoineta Diaz, Direct Services Coordinator

Anna Dominov, Counselor/Advocate

Roxana Licon, Counselor/Advocate

APNA GHAR, INC.

Kiran Siddiqui, Program Director

MUJERES LATINAS EN ACCION

Kathleen Kelly, Coordinator, Women in Transition Program

HIV/AIDS CONCENTRATION

Concentration Leader: Abbas Hyderi, MD, MPH

Partnering community agency

EDGEALLIANCE

Eric Homer, Vice President

Justin L. Hill, Program Coordinator

HOMELESSNESS CONCENTRATION

Concentration Leader: Nimmi Rajagopal, MD

Partnering community agencies

CATHEDRAL SHELTER OF CHICAGO

Kevin McCullough, Executive Director
Janette Christophe, Manager, Cressey House

DEBORAH'S PLACE

Julie Nelson, MPH, Health Services Coordinator

INTERFAITH HOUSE AND RESPITE CENTER

Pamela Kerr, MSW, Program Director

IMMIGRANT & REFUGEE HEALTH CONCENTRATION

Concentration Leader: Andrew Dykens, MD, MPH

Partnering community agency

HEARTLAND ALLIANCE

Darwensi Clark, Manager, Resettlement and Placement Services &
Adjustment and Employment
Lauren E. Pérez, Program Assistant

M3 COMPONENT: PATIENT EMPOWERMENT SELECTIVES*

Maureen Gecht-Silver, MPH, OTR/L
M3 Component Leader

Christine Bobek, MS, RN
M3 Component Co-Leader

***Short Courses in Family Medicine Clerkship**

M4 COMPONENT: REFLECTIONS ON PATIENT-CENTERED CARE**

2009–2010 M4 SLP CO-TUTORS

Melina Beaton
Anita Bordoloi
Vikas Desai
Christina Gamboa
Ariel Leifer
Jennifer Stromberg
Shea Suskin
Renee Westley

****M4 Elective**





***Reflections by
M1 PCM Scholars***



Musings on
becoming a
physician

Biochemistry, Histology, Gross Anatomy, Physiology, Nutrition, and Neuroanatomy are but some of the classes that have taken up the overwhelming majority of my time during my first year of medical school. I have dreamt about anatomy at night. I have questioned the nutritional value of my meals. I have wondered at the physiology behind several bodily functions. I have surrounded myself with countless books and memorized so many things I feel as if my head will explode. What am I doing all this for? When an eight year old kid proudly claims that he wants to be a doctor, does he know he will be spending all his waking time during his first two years of medical school buried in books? Does he know he will frustratingly fiddle with a microscope to get a better look at various epithelia? Does he know he will struggle to remember all the hormones in the body, what they are made by, and what their actions are? I highly doubt he thinks about this, but this is the reality he will inevitably face.

For me, there has only been one thing this year that has altered my short-term perspective and given me a peek at the future to come, however distant it may seem currently. Only when I spend time with my continuity patient do I really think about why I'm going through all this. To me, HIV is a topic, a disease, an abnormality that destroys T cells. To my continuity patient, it's reality, it's life. He doesn't need to read a pathology textbook to remind him of the symptoms and signs of HIV infection. He can see it in himself; he can see it in his labs. Most of us can't even imagine what it would be like to have HIV. We know how devastating it can be; we know how many millions of people it has killed and will continue to kill. Yet, we, as medical students, don't really know what it's like to be affected by that. My patient lives it; he knows exactly what it's like. He knows what exactly it will do to him if he doesn't take care of himself to the best of his ability.

This is where Patient-centered Medicine comes in for me. It forces me, in a good way, to appreciate the value of my struggle and take note of how it pales in comparison to my patient's struggle. There is much more to being a physician than just memorizing an obscene number of facts. The point of being a physician is to help others tackle problems that they simply can't on their own. Just think about how dependent a patient in need of surgery is upon his surgeon. The patient needs the surgeon to do the surgery and fix a problem that he can't fix himself. PCM afforded me the opportunity to look at medicine from the patient's perspective. To my patient, medicine isn't just knowledge to master, so that I can prove my competency on tests. It is a solution to a life-threatening condition. He depends on his physicians to help him gain access to a solution, a solution he can't implement on his own. We, as medical students, should always be mindful of what medicine can do for our future patients and how they will ultimately depend on us to help and guide them.

Sumant Tumuluru

Written as M1 PCM Scholar

Complete Physicians

I am writing this essay because it's required of me. I hate to admit it, but there it is. Actually, the fact that I am writing because of a requirement is what I want to write about.

In medical school we are trained as scientists. We look for the answer. We are trained as finders of single truths and appliers of research. Teachers lecture, patients present. We frantically scribble notes and fill in gaps in knowledge. Evidence-based medicine, clinical trials that we know all science behind, physical exam skills, symptoms, diseases, drugs, drugs, drugs, and more drugs, surgery. Patient visits, with lists of questions for us to memorize and ask them. It is an overwhelming race.

I am NOT here to complain about the hours we are required to put in as students. It is a good thing that medical school is overwhelming at times. Medical school needs to be difficult, it has to push students to their limits. The crush of schoolwork is the most effective way to forcefully equip us for the nearly slave-like existence of internship year, our residencies, careers as attending physicians. Whatever circumstances your life adds to medical school are just that: your outside circumstances. If you want to be a good physician, you need to learn how to deal with them alongside medicine. Service is the better part of your life now.

But once the long to-do list pushes us to a point where we have internalized the race for every last factoid we can handle, there is a disconnect. Just how, exactly, do we deal with the circumstances surrounding medicine in our patients' lives?

Here's an example of what I mean: Say a patient, during a family medical history, breaks down because he has to remember his wife and her slow death by pancreatic cancer, as part of the questions I am asking. As an empowering professional and a teacher, where are my skills to help him—even in a small way? Honestly, I don't have the slightest clue. Situations like these are left to unproductive thoughts at the end of the day, as I am drifting off to sleep (or not) after drilling more science into my head. There is no open space, there are no unstructured, open-ended requirements given to me in school. The institution rarely requires me to help my patient beyond scientific thought.

This is terrible because the science of medicine is an important part, but not the only part of making people healthy. Scientifically we search for single answers—what disease does this patient have, and how do we fix it? But the art of medicine, equally difficult, is the open-ended search for the patient—what are the millionfold truths and issues adding up to the health of any patient we see? We are left half-educated in medicine. And ultimately medicine, even the best-practiced medicine, does not equal health, either for the practitioner or the patient. Freedom from violence, pollution, loneliness and food deserts are equally powerful players in health. But as future physicians, we are left without any education on how to approach these “soft” non-medical things. We are not trained to meet the non-medical health needs of our patients. I suggest that medical school, then, needs to become about more than medicine.

The solution, in my mind is a simple, but devastatingly difficult decision for medical educators everywhere. Science, which is what is tested in the USMLE, can only be learned by approaching the world with a reductionism paradigm—asking mainly “How is this working?” Conversely, art can only be learned approaching learning as a chance to create. Art involves lots of open-ended questions with no right answers, science a barrage of multiple-choice exams.

So it comes to this: can we trust medical school students, one of the most intelligent, tunnel-visioned, and passionately altruistic groups of people on the planet, to give of themselves in creative assignments, in place of at least one exam? Can we expect it of them? And what’s more, can we trust them to create in their very first days as medical students? Even if it means spending less time teaching to the USMLE?

I say educators can, should, and must demand art of students. If patients trust us, believing that we are complete physicians, then it is about time medical educators expected us to become complete physicians. It is time we demanded our institutions meet the needs of the people we serve. It is time that we started internalizing the drive to create a unique picture of each patient we see. The twisted irony of these demands, of course, is that I am writing in an unstructured, open-ended assignment. I was required to create something. Consider it a step in the right direction.

Ben Goold

Written as M1 PCM Scholar

Good and Great

A good physician took five minutes to make
the diagnosis and then left
A great physician stayed the full fifteen
minutes anyway

A Drive-by Doctor

An old man comes in
and we treat the gunshot
wound
But his limp remains

Gurvinder Bhardwaj
Written as M1 PCM Scholar

I used to believe that good physicians remained distant and professional. I thought that using few words meant that the physician was smart and direct. Today, I have a different perspective.

I have learned so much from shadowing my preceptor these past few months. I have witnessed that you can be direct with your patients but still take time to educate and empower them. I have learned that patients really appreciate it when a provider takes more than fifteen minutes with them. Instead of flying through the visit, my preceptor takes her time to catch up on the lives of the patients before addressing the reason for the visit. This at times puts her behind in her schedule, but every patient waits eagerly to see her.

The idea that doctors should be on a saintly pedestal is slowly declining. Patients should be able to relate to their doctors. When doctors are humble, the patient appreciates it and can easily approach the physician with questions.

I have been truly inspired by watching patient-physician interactions during my time in the PCM Scholars Program. I hope that I will never forget what I have learned.

Janet Cruz
Written as M1 PCM Scholar



The Role of a Physician

Why are physicians sometimes satirized as being cold and impersonal? Why do some people hate going to the doctor so much? These simple questions elucidate a multifaceted and fundamental problem of healthcare—the physicians' role and responsibility to their patient. How do we strike a balance between cool, objective professionalism and our natural human tendency to be personal, inquisitive, and forthcoming? Being a part of the PCM Scholars Program has strengthened my belief that this balance tips from patient to patient, and that the best way to find an equilibrium is to follow your heart. Even though we are placed in a position of authority, we should never forget our fundamental duty is to treat our patients as we would wish to be treated - because they are real people with real problems—just like us.

From what I can gather at the moment, being a physician is just as much an art as it is science. Art in the sense that it requires us to internalize a massive body of knowledge in a remarkably short amount of time, but also to be able to relate this plainly, concisely, and effectively to our patients. Art also in the sense that we have a plethora of technological advances at our disposal to accurately diagnose and treat our patients, to facilitate their rapid and comprehensive recovery. I consider being a physician is an art principally because we are somehow magically supposed to remain humanistic despite four-plus years of constant peer competition, having our self-worth being determined by a series of numerical values, and being inundated with prodigious amounts of debt. What is it in us that can help us persevere and remember our original commitment to medicine—to serve those who need it the most, with dignity?

I am a firm believer in the mantra that you can't give what you don't have. I extend that to many spheres of my life including my academic career, inner peace, and personal health. Meaning that in order to become a good doctor, I need to have all of those things in order before I can help others. The beauty of medicine (especially in terms of coursework) is that there are always exceptions. Another significant one I am willing to posit is that this ever-elusive inner peace and perseverance will come not from inside of ourselves, but through our interactions with

our patients. It is the patients that put a smile on my face, the mundane conversations that help ground me, and the simple show of gratitude that helps me to persevere.

Being a part of the PCM Scholars Program has been an educational experience in the fullest sense of the definition. My role as a student physician was probably the most trivial one I played, probably due to the amazing dedication of my mentor. I really didn't have much to offer to our patient except for translating the occasional medical term or test result. In terms of my preceptor, I have yet to meet such an open and personable doctor as Dr. K. She has shown me the beauty of patient continuity and that the difficulty of keeping tabs on patients is more than repaid with the strength and intimacy of the doctor-patient relationship. In terms of my patient, she has helped me demystify the world of patient interaction. Through her, I became more aware of individuality—in terms of perspectives, behaviors, and habits. She helped me see that in order to take advice, you really need to feel close to someone and trust them. Which is precisely the atmosphere that my preceptor has managed to cultivate.

The PCM program has shown me a glimpse of what my future as a physician can be. It has introduced me to the work of a dedicated physician and substantiated the idea that patients are real people with real medical problems. It showed me that the most important factor influencing patient care is treating the patient as a person, and that trust between doctor and patient is established in the same way as it is everywhere else. Actually wanting to get to know your patients is the fastest way to really show you care. I think that only when we mentally hang up our white coat—stop hiding behind that ostensible bastion of authority—we will be able to learn from our patients and return the gift of openness and trust we have been given.

Greg Podolej

Written as M1 PCM Scholar

As a first year medical student, I used to feel as though my duty is just to get through my M1 coursework and learn how to conduct thorough and complete patient histories. However, being a part of the Patient-centered Medicine Scholars Program, I am reminded of my purpose and vision as a future physician. I am reminded that I can do more and play a more involved role in my patients' lives, even this early in my clinical training, while keeping my vision of practicing medicine within arm's reach.

I have a strong desire to pursue family medicine as a career. My extensive experience in public health and my desire to maintain strong and ongoing relationships with my future patients are what drive me to enter this field. The PCM program has done a great job in giving me early exposure of that patient-doctor relationship via my continuity patient experiences. I have gained first-hand knowledge of the importance and necessity of this type of relationship.

Laurine Tiema

Written as M1 PCM Scholar





insights on
patient-centered
medicine

After a year as a participant in the Patient-centered Medicine (PCM) program, I sit back and ask myself, “What *really* is Patient-centered Medicine? Have my views of it changed over the last year?” Simply put, PCM means a provider meeting patients’ needs, whatever they are (e.g. economic, emotional, nutritional, etc.) That can be achieved through a treatment plan, a home visit, or just a simple conversation. My understanding of PCM has matured through my experience this year. My definition of PCM has not changed, but I’ve now seen real life examples of exactly what it entails.

Luckily, I had the privilege of having a wonderful preceptor who taught me the demands and rewards of practicing PCM as a physician. This was most evident after visiting with one homeless African American male—Mr. M. He was in his early 50s, a Type 2 diabetic for the greater part of the last 10 years, and armed with a dynamic and charming personality. Mr. M was an intelligent guy (you could easily gather that after a brief conversation with him) with little formal education. Before coming to my preceptor, he never had a steady primary care physician. Moreover, without a consistent place of residence or job it was not uncommon to go part of two or three days without eating. As one can imagine, this lack of food security does not lend itself well to managing blood sugar levels. So my preceptor had to devise a program for Mr. M to adjust his diabetes regimen based on whether or not he’s eaten that day and how much he ate. During the course of his treatment, my preceptor had to assess Mr. M’s education level, and teach him concepts like what a sliding scale means, and how to properly add and subtract—patient skills that students aren’t necessarily taught in medical school. Patient-centered medicine is about going the extra mile to fully comprehend what a patient’s life situation is and using more often than not your non-medical skills to ensure the provider and the patient are following the same treatment plan.

When I took Mr. M’s HPI, he talked to me at length about his illustrious sexual history—I really felt like I was talking to Wilt Chamberlain at times. When I asked Mr. M if he used protection, his answer was, “I know what science says, but I’ve never used it, and I ain’t got no bugs now. Besides, I’m a good judge of whether or not women are clean or not.” I tried to explain that he can never truly know by someone’s outward appearance or actions whether or not they are infected with any STIs or HIV in the hopes of convincing him to wear protection. As much as I wanted Mr. M to wear protection, he didn’t want to. Patient-centered Medicine is about being persistent.

Mr. M later revealed to me that he had a daughter that he didn't know because he was incarcerated for a majority of her twenty-seven years of life. When I asked him if he ever tried to contact her, Mr. M asked quizzically, "For what? What do I have to offer her?" He later confided that his daughter had tried to contact him several times after discovering him. She even tried to introduce Mr. M to her fiancé. But he just told me, "I just look at her, whenever I see her because what is there to say? Nothing." My heart really bled for him at that point, and as much as I wanted to convince him that a relationship with his daughter was worth it and would enrich his life, Mr. M did not feel that was a priority for him. It is hard to argue with a man who is just worrying about feeding himself on a daily basis.

One often-harsh reality for providers is that patient-centered care actually means care centered around the patient's wants and desires (given those wants do not violate ethical, legal, or professional principles). The desires of a patient and his/her provider will not always be in accordance. While at times patient desires are malleable after explanation or additional trust in the provider, other times they are not. That is, perhaps, the toughest pill to swallow.

I feel my experience with Mr. M took me through the whole emotional roller coaster that PCM can be. PCM means the joy of successfully managing a patient's diabetes struggling to do so initially. PCM means the frustration of trying to convince a patient to change a lifetime of sexual practices. PCM means feeling a patient's pain of a broken relationship due to a mistake made several years ago. PCM means using patient's trust and cooperation to achieve better health for that patient. At the same time, PCM means learning humility, knowing that as a provider you cannot change everything in the patient's life and you can accomplish very little without the patient being on board. Nevertheless, PCM means tenacity. While providers change everything, there are many areas of the patient's life they can influence. In those areas, they should fight tooth and nail to achieve better health for the patient. That means fighting pharmacies, landlords, bureaucracy, and sometimes even the patient to ensure that the patient (with the support of his/her family) implements that positive change. PCM is what medicine should be.

Badewa Fatunde

Written as M1 PCM Scholar

The concept of patient-centered medicine was a philosophy that I believed, as an incoming medical student, was focused on the working relationship between a doctor and a patient in determining the patient's course of medical treatment and coordinating the patient's treatment with other doctors or specialists. Although I still believe these ideals to be critical aspects of the PCM viewpoint, I have found through my experiences this year that the heart of the doctor-patient relationship in patient-centered medicine takes place outside of the clinics. While working with my preceptor, I realized that diagnosing the patient and following up with other doctors are challenging, but manageable tasks. Ensuring that the patient was following the proper course of treatment outside the doctor's office, however, is an incredibly challenging undertaking, which requires a great deal of effort and emotional energy. My work with my continuity patient, as well as numerous other patients, taught me that patients do not always want to follow up with treatment, and on many occasions can prove to be quite stubborn. And it is because of this fact that I now realize that the patient-centered doctor must be diligent also in working with the patient outside the clinic in order for treatment to be effective. Working with a patient to develop the right treatment plan is useless if that plan is not followed. Although it is a difficult task, I have found that it is also extremely rewarding when one can help a patient to follow a plan and the patient's health improves as a result. Therefore, as I am ending my first year of the patient-centered medicine, I leave with the understanding that patient-centered medicine is not just about focusing on the patient in the clinic; it is about keeping the patient's best interest in mind at all times and taking whatever steps necessary to ensure a patient's good health.

David Kosoff

Written as M1 PCM Scholar

Patient-centered Medicine: Developing Relationships

Patient D.C. was recently released from the hospital for kidney failure. During a recent CT-scan, contrast dye was used, despite the yellow flag in her electronic medical record noting that the patient was allergic to contrast dye among other chemicals. She has visited her primary care physician the day before noting that she just did not feel right. Her physician ran blood analysis tests and noted that her kidneys were in distress. The physician called the patient and asked her to check into the hospital right away. D.C. was tired and exhausted after a day at work and her illness. She just wanted to go home and rest.

D.C. talked to her sister on the phone about the turn of events. After all, she has been in the hospital so often, for other illnesses and surgeries. While talking to her sister, she decided to follow her physician's advice and check into the hospital. She did not believe she needed to be in the hospital, but concluded that if her doctor was concerned then she better listen. D.C. had a long-term relationship based on trust and respect with her doctor. Her physician earned her trust and respect through focusing on her needs, concerns and health during each visit for many years. D.C. would have gone home to rest and likely suffered long-term damage to her kidneys without a physician who was committed to her and her health. She paid the physician the highest compliment during the follow-up visit. "I figured that even though I did not want to go to the hospital, I figured if you were concerned, then I had better listen."

It is an honor to work with a physician who teaches patient-centered medicine by modeling it.

Kathleen Mendel

Written as M1 PCM Scholar

Participation in the PCM Scholars Program has been both enlightening and formative. Through observation and work with my preceptor, his patients and my continuity patient, I have developed the skills and attitude needed to practice patient-centered medicine, to better understand and relate to patients as people, and to build trust and effective partnerships with patients to promote their health and well-being.

My quest to find a continuity patient was difficult in the beginning. While I was able to practice speaking to patients and establishing rapport, and also to learn about patient flow, the coordination of care and the basic aspects of office practice, my preceptor and I could not identify a willing and appropriate patient for me to follow and assist in his or her care management. For the first half of my clinic visits, I was without a continuity patient and I began to feel discouraged.

Finally, on my third clinic visit I met a 31-year-old African American woman whose chief complaint was loss of energy and heavy menses due to fibroids. We took a blood sample and found that Ms. H was dangerously anemic. My preceptor prescribed iron pills, which Ms. H had taken previously, but discontinued when her prescription ran out, and also referred her to a gynecologist for her very large fibroids, which were presumably causing the excessive bleeding and the anemia. While conducting a complete history, Ms. H and I connected. I felt that she would be a perfect patient for me to follow and that we would both benefit from the relationship. My preceptor agreed and explained to her the program and the role I would have in her care, if she chose to participate. I was happy and relieved when she agreed to be my continuity patient. We have now been in contact since January. I have called her several times in the past few months to check on her and to make sure she is still taking her iron pills. I also recently accompanied her to gynecology appointment. At times, I felt awkward and bothersome when calling her and it was difficult for me to define my role and the necessity of my involvement in her care. At points, I worried that the relationship was more for my benefit than hers. However, I was rewarded with the reassurance of having some positive impact when I went with her to her follow-up appointment in gynecology. I was able to assist Ms. H in filling out her paperwork, to answer questions about terms with which she was not familiar, and talk to her about her life and her struggles with

losing weight and staying on the iron pills which had many side-effects. I believe I was able to provide useful advice and encouragement in these areas. At the end of the day, when we were leaving the clinic together, Ms. H made a comment that made the whole experience worthwhile for me. She simply said, "I'm really glad you came with me today." At that moment, I knew I was not a bother, but a friend and person whom she could trust and look to for support and advice.

Through this experience I have learned a great deal about what patient-centered medicine is and how to practice it. I have grown in confidence and have learned how to approach a patient with compassion and understanding in order to gain trust and to better provide care and guidance. I now understand the concept of seeing the patient as a whole person and treating him or her as such, and I have seen the benefits of this approach in patient satisfaction and compliance. I began this program with an idealistic and optimistic view, I grew discouraged along the way, and then regrouped and recommitted to it in the end. My advice for anyone in the PCM program, and for anyone working with patients in general, is to always think of the patients first, to respect their feelings and wishes, and to keep working for them, for what they want and what is best for their health and well-being. Do not get discouraged when things don't work out every time, with every patient. Just keep in mind our goal as health care providers is to be an advocate for the patient and to ensure that they get the care they need and will accept.

Rachel Guild

Written as M1 PCM Scholar



At the start of the program, I was knowledgeable about the idea of patient-centered medicine; but not until participating in the PCM program, have I been able to completely understand this definition. For this reason, I have gained a very high respect for primary care physicians who are able to successfully practice the essential fundamentals required in Patient-centered medicine.

An urban clinic, such as in the city of Chicago, is presented with great diversity among its patients whether it be in socioeconomic, religion, culture, sexual preference, etc. It takes more than just an outgoing person to be able to connect and develop a relationship with every patient that presents in the clinic. This connection is critically important if the physician expects the patient to be open and also compliant with treatment, follow-up visits, and/or life-style changes. I was extremely impressed with my preceptor's ability to connect with every patient that came to see him. Establishing this mutual partnership provides not only better treatment for the patient but also makes the physicians' job more satisfying and in turn prevents burn out.

I also gained a greater appreciation for the broad knowledge base that primary physicians need to have. Along with traditional medicine, primary care physicians need to be versed in whatever the patient is taking part in. This may be herbal supplements, various forms of alternative modalities, and even a wide range of life style practices (sexual practices, drugs, etc.). There has been multiple times that I was in the clinic that a patient spoke of an unknown herbal medicine or even a slang term for a type of sexual acts she practices in.

Lastly, the PCM program has changed my view on the way to care for patients. The primary objective for any patient visit is to establish the primary goal of the patient. In some cases, the health and well being of the patient may not be at the top of their list. The patient may have financial, employment, or family issues that are more pressing. The physician needs to be aware of these issues to establish a better treatment plan for the patient, or even to understand and see why there is an issue with non-compliance. For example, it is completely ineffective to schedule appointments for a patient who has no mode of transportation to the clinic or prescribe medications they are unable to afford. I directly had to

work with one patient to help determine the best anti-depressant medication for them. Every SSRI has specific side effects, with some being greater than others. It was needed to discuss with the patient his priorities in life and see which side effect of drowsiness, nausea, sexual difficulties, appetite change, etc. the patient could tolerate in his day-to-day activities.

Before entering the PCM program, I worked in a clinic as a technician for a year. Following this experience, I vowed to myself that I would not enter primary care due to non-compliance and frustration with treatment of chronic diseases. I entered the PCM program as a way to force myself to not just focus on specialties that deal with mostly acute illnesses and better develop myself as a well-rounded physician.

I enjoy my participation with the PCM program greatly. Patient-centered medicine is establishing a mutual partnership between the physician and patient to attend to the mind, body, and soul of the patient as a whole. This attempt to define patient-centered medicine has been modeled through my experiences with working with my PCM preceptor and continuity patients. In the next couple years, I will continue my search of what field of medicine will fit me best. Attributed to the PCM program and to my astonishment, I will again reconsider primary care as a future vocation.

Brian Sindelar

2LT, MS, USAR

Written as M1 PCM Scholar



The patient was not happy. I knew this, even before I glanced at her vitals on the yellow sheet. The MA had mentioned to Doctor that a patient had been “waiting” and “was not happy”. I heard this, of course, because I was in my normal position, standing directly next to Doctor. After working on two more patients, I went in to see her. Like I said, she was not happy.

Knock, Knock, entering.

— Is this the normal way that this clinic does things?

— *(confused expression on medical student's face)*

— Is this clinic always running 40-45 minutes behind schedule?

I was not sure how to respond. In truth, I had made the same observations over the course of three previous preceptor visits. I didn't think it was particular to Doctor; I thought it was just the normal way that this clinic did things. I took the easy way out.

— *(with continued confused expression, in hopes of putting across the idea that the medical student was a mere deer in the headlights, the wrong target for this upset patient's Chevrolet Suburban of wrath).* I am a first-year medical student. I do not know if it is always like this. I am here today gaining experience at interviewing patients. Would it be okay if I ask you some questions before Doctor comes in?

— Okay, go ahead.

This seems to me the central challenge of patient-centered medicine: it takes time. Unless you get the first appointment of the day, you are pretty much stuck. The MA comes in and takes your vitals shortly after putting you in the room and then you sit there and wait. True, you are free of the waiting room with its inherently ill air and the small children with their distracted mothers. But you still must wait. The drug company sponsored posters of Common Medical Conditions bore quickly. You pass on the three month old dog-eared copies of uninteresting magazines. You hear people walking. And talking. But they are not entering, not yet. Just when you give up and decide to call your friend, Doctor comes in, with medical student. You hang up quickly. The Doctor will see you now.

- Lastly you tried taking Tylenol, but that did not really help. Am I leaving anything out?
- No, I think that is everything.
- Okay. I will be sure to mention your frustration with the time delay to Doctor. Is there anything else that you want to talk about today?

I always ask this last question, even as I realize that I am playing Pandora by asking it. We are taught early on to make a focus for each visit. “A patient with three or four complex medical problems cannot have everything solved in a fifteen minute visit.” And yet, I ask. Over the course of this year, I have become sensitized to the patient sitting across from me. I thought that I would do this naturally. But the program has taken me a step deeper. I identify more strongly with the patient than I do with Doctor. My instinct is to apologize profusely for the time delay, declare my respect for the patient’s time and acknowledge that we must do a better job.

But maybe I am too fresh in my training, still on the bridge that separates the patients from the doctors. As a patient, I cannot recall any doctor ever apologizing to me. The message seems to be: I should be grateful for the time I get, even if it is an hour after my appointment. And besides, what alternative is there? The only real solution seems to be getting that first appointment, before each successive patient has a chance to talk to Doctor. And besides, what alternative is there? The appointment always takes longer than fifteen minutes when a life, not merely an individual body part, is the exam. Without more time given per scheduling, we will always be late.

Our normal way is taking care of our patients and that takes time. Still, I apologize for the delay.

Benjamin Carney
Written as M1 PCM Scholar

Ten Things I've Learned from the PCM Scholars Program

1. Sometimes I can learn more about a disease from a short book or brochure that my continuity patient brings for me to read than I can from gigantic textbooks or lectures in class.
2. At first, I wished I were assigned to a preceptor who was located closer to school so I didn't have to travel so far...when I realized that some of the patients he sees travel up to an hour and a half to get to their appointments, I didn't feel that my 20 minute commute to the clinic was that bad.
3. Some patients know a lot more about health care than I do.
4. Fifteen minutes for returning patients and thirty minutes for new patients is not a lot of time to talk about all of the health concerns that patients have, no matter how skilled you become in history taking.
5. Even patients with a legitimate laundry list of medical issues may perceive themselves to be hypochondriacs and be hesitant about bringing something up during their visits.
6. Listening for lung sounds requires that you use the side opposite of what you use for heart sounds.
7. It is amazing how much information a family medicine physician needs to have at his or her fingertips.
8. We are repeatedly told how important it is to not get off topic when talking to your patient, but when the patient is adamant about telling you their life story, this is easier said than done.
9. It's very easy to get lost in the maze of the hospital and outpatient center.
10. No one knows their health better than the patient themselves, and really taking the time to listen to their concerns and perspective make a world of a difference when helping to make a plan for their health.

Ivana Brajkovic

Written as M1 PCM Scholar

Often, a patient's voice is lost in the complexity of today's healthcare system. As first year medical students, we are beginning to understand firsthand how convenient it is to overlook the patient's viewpoint. Our schedules seem overextended already, too full with the excessive amounts of material to master for the next test, which comes all too soon. Occasionally, we ponder how to best manage our time and not "lose" ourselves during medical school.

Most of us acknowledge that high scores alone do not produce the "good doctors" that patients can trust. A look at the literature reveals a refocus on patient-centered medicine. Most health professionals agree that the patient should be at the center of the healthcare team.

Given the ever increasing demands on our time during medical school and beyond, how can we practice patient-centered medicine and actively foster a patient-centered medical culture? While there are no easy answers, situational awareness is a good, first step.

Our participation as PCM Scholars signifies our commitment to this professional evolution. Our actions will most certainly speak more faithfully and resonate more strongly with those seeking care, much more so than any title we may write on a curriculum vitae or résumé.

Kajorn Kitiphongspattana
Written as M1 PCM Scholar

Prior to participating in the PCM Scholars Program, I had been involved with a range of clinical experiences that offered ample opportunities to observe physician-patient interactions. I pursued these opportunities with the expectation that they would provide inspiration that would fuel my own decision to become a physician. Surprisingly, the interactions I observed were not always positive. I saw harried physicians quickly dismiss a patient's input. I overheard clinical staff mock a patient's concerns. I even viewed physicians attempt to force an invasive procedure on an elderly woman in distress, laughing rather than listening to her objecting cries. I couldn't understand how these physicians, who had devoted so much of their lives to caring for others, could be so quick to belittle those in need, to view these patients as annoyances or problems rather than human beings. Granted, these regrettable encounters were few, but I could never forget them. Yet instead of being discouraged by them, I have used them to form a foundation of how not to practice medicine and am determined to adhere to basic personal principles in my own delivery of clinical care, e.g., giving patients full and sincere attention, listening thoroughly, and banishing judgment and assumptions.

Through the PCM Scholars Program, I have, with tremendous relief, found confirmation of these ideals in my faculty, classmates, preceptor, and patients. I have been able to meet and assist patients of all ages, and with a wide range of medical conditions. I have encountered patients of varied ethnic and socioeconomic backgrounds, and have worked with them to overcome barriers of language and finances in order to obtain the care they need. I have had the enormous good fortune to observe and collaborate with extremely devoted caregivers, who manage to see a seemingly endless, diverse array of patients over a single day, yet begin each patient visit with fresh eyes and open ears. I have heard fellow students candidly describe their challenges with patients, and have appreciated their commitment to seeking solutions. The ceaseless opportunities for learning, the sharing of valuable knowledge and experiences, and the great dedication to compassionate care I've encountered have all exceeded what I initially thought the PCM Scholars Program would provide. The inspiration I was seeking before? I found it.

Dempsey Hughes

Written as M1 PCM Scholar

Working in the PCM program this year has taught me that a physician should put health care in the hands of the patient as opposed to dictating to them what they should do. Taking this approach with patients leads to better adherence and outcomes. Moreover, building a relationship with a patient through the PCM Scholars Program has shown me a new view of the physician-patient relationship. In the future, I will be sure to carry the values of empathy and trustworthiness with my patients as a physician.

Luis Grau

Written as M1 PCM Scholar



My first experience in an emergency room in the U.S. made me realize not only the need for caring physicians but also the need for bilingual ones. About ten years ago, while waiting for my sister to come out from the emergency room at the Cook County Hospital because of a broken arm, I met an older woman named Gloria who was waiting to see a doctor. When I asked her how long she had been waiting, she said “doce horas porque espero a un traductor” meaning “twelve hours because I’m waiting for a translator”. She just needed someone to translate for her and I offered my help. A physician saw Gloria fifteen minutes after I told the front desk that I would translate for her. This episode as well as my own experience reinforced my desire to become a physician and gave me the determination and motivation to reach my goal.

My life in the United States began about fourteen years ago. A month after my arrival I started high school. In the beginning I struggled because I did not know any English. Aside from this, I also had to face financial difficulties. My mother is separated from my father, and was therefore forced to provide for my two sisters and me on her own. Thus I had to rely on health clinics that were either free or provided services at a low cost because I had no insurance. I have experienced what is like to see a different doctor every time I felt sick. I know how hard it is not to have a consistent relationship with a physician who knows you well.

PCM has given me the chance to work with a wonderful preceptor who has taught me that it is not only necessary to have a medical degree to help patients, but that there are other key elements necessary for providing good quality of health care. Among the most important are compassion and having the ability to listen and understand.

Working with my assigned patient made me realize how having a close relationship with patients can improve outcomes. As a medical student, I had more time to call my patient and follow up

with the needs that she had. I realized how a lot of times patients don't understand how to manage their chronic conditions. For instance my patient was diagnosed with diverticulosis a couple of years ago and she did not know the eating changes that she needed to make due to her condition.

My PCM experience showed me that as doctors we have to understand human nature and that when a patient does not comply it is not always because they don't want to listen to the doctors but because making difficult changes in life or dealing with the side effects of medication is not an easy thing. This experience also showed me how important it is to have a physician who speaks the patient's native language and is accessible, so that a good long lasting relationship is established.

M. Elisa Hernandez

Written as M1 PCM Scholar



My PCM Scholars Program Experience

When I decided I wanted to go into medicine I believed it was an obvious expectation of all physicians to practice with empathy, respect, and cultural competence and to treat their patient as a whole person, not just their illness. I had an understanding of what patient-centered medicine was, but I didn't realize this type of care had a name and that it was a distinct type of care that many patients do not receive.

When I first heard of the PCM Scholars Program at UIC, I was intrigued, and it seemed a natural thing that I wanted to be a part of. Throughout the course of the program, I observed techniques of my family medicine preceptor, and of more value, I was able to practice them. Interviewing a patient is the physician's first opportunity to get to know their patient as a person, why they are seeking care, and critically relevant, what their opinion is of what they have and what outcome they hope to achieve from their visit. The various experiences I had in clinic with my preceptor have made me confident in my ability to ask the right questions and elicit this information from my patient.

Another unique opportunity that the PCM Scholars Program offers students is the experience of working longitudinally with a patient. Being part of a patient's long-term care involves educating the patient and involving them in the decision making, ensuring they experience smooth and secure transitions between health care settings, and following-up with patients to make sure they are satisfied with their treatment and care outcomes. I feel fortunate to have been able to work longitudinally with my continuity patient. It was a great learning experience and I appreciate it more, having seen how grateful my patient was for my help. When patients get a sense from their physicians that they really do care about them as a person and not just as their patient, they are appreciative and more likely to trust their physician.

Finally, the most important thing I discovered through this program is that the satisfaction that comes with patient-centered medicine works both ways. Not only is the patient more satisfied with their physician, but the physician gets a sense of fulfillment and reassurance of their purpose in medicine. If physician reimbursement were based on the quality as opposed to the quantity of services provided, it would encourage more physicians to adopt this type of care.

Hopefully, patient-centered medicine soon will become the universal model for delivering care.

Shari Vasquez

Written as M1 PCM Scholar

I entered the PCM program not really sure what I would get out of the experience. I moved a lot growing up and also had quite a few medical problems, and therefore had seen more than my fair share of doctors. I thought that I had seen enough bedside manners to understand how doctors operate around their patients.

It only took one shadowing session for me to realize that Dr. MP was different than any other doctor I had ever encountered. He was really focused on giving the patient what they wanted, not just a predetermined plan that he thought would be best. One patient encounter in particular showed me how Dr. MP practiced medicine different than any other doctor I have seen.

The patient was coming in for a follow up visit after complaining of chest pains in the previous visit. Dr. MP had run an ECG and determined that there were no heart problems, and he was fairly confident it was nothing serious. At this point most doctors would send the patient on their way telling them that nothing was wrong with them.

However Dr. MP took a very different approach, he was really concerned with what the patient was feeling. It was evident the patient was concerned with his condition, and would not have been satisfied merely being sent home. Dr. MP gave the patient the option of getting a chest x-ray to rule out the chance of cancer, even though he thought it was extremely unlikely given the signs and symptoms. The patient decided to have the x-ray and it was evident that this plan of action made him much more at ease.

This patient encounter taught me that it is always crucial to understand the patient's wants, needs, and desires because only when you understand the patient will you be able to deliver truly patient-centered medicine.

Nathan Stackhouse

Written as M1 PCM Scholar

My PCM Experience

My experience in the PCM program at UIC-COM was an opportunity for me to play the role of a “real, practicing” physician – albeit one that initially had no formal training in direct patient interaction, physical examination skills, or history taking skills. Walking into clinic on my first day of PCM, I did not know what to expect, I had heard both the good and bad stories regarding previous students experience with their PCM continuity patient and/or preceptor. Was my patient going to like me? Was he/she even going to talk to me? Would my preceptor allow me to interview patients on my own? Or would I just be shadowing her? I truly had no idea what to expect.

My continuity patients were both men who had a myriad of chronic health problems. They were reluctant at first to open up to me and viewed me more as a novel curiosity at best. However, as I began to talk to them and interact on a non-medical level, they started to view me as someone that was interested in them as a person and not just as a medical curiosity which in turn made them feel like they could trust me. One of them was a big fan of James Bond movies and we would talk about our favorite movie scenes and Bond characters before launching into his health issues for the day. I learned that viewing your patient as a human being and not just as a medical concern was crucial because it determined whether they viewed you as a merely aloof, disconnected doctor or as a trusted confidant, friend, AND doctor.

Dr. NR, my mentor at the clinic played an instrumental role in my learning experience in the PCM program. She understood the role of the PCM program and how I, a relatively unseasoned M1 student, could benefit from this. I was given the freedom to interview patients independently and thus allowed to fine tune my history taking skills and patient interaction skills. After my initial talk with the patient, I would present my patient to Dr. NR who would then proceed to point out any errors or oversight I had committed in my history taking or physical examination notes. These Q &A sessions between my mentor and I allowed me to fine tune my history taking skills and allow me to become a better interviewer of patients. Dr. NR also never let me become content with just one type of patient. Once I had become comfortable with my adult, male continuity patients, I was

made to take histories for infants and women who were both at the clinic for a vastly different set of health problems and concerns. This dynamic element in my PCM experience always kept me on my toes and provided me with another opportunity to expand my knowledge and skill level in patient-doctor interactions, history taking, and physical assessment skills.

In summary, I would conclude that the PCM program forces you to use the skills you have learned in the classroom setting and ECM and apply it to real people and real situations. This is both exciting and nerve-wracking because you never feel like you are fully in control of both the patient and the history taking material and diagnostic skills that you feel like you should know like the back of your hand. It can be a confidence shaker—but if you persist, it can be a truly rewarding experience to see your patient open up to you and look to you for guidance and support through difficult times in their lives. You will make mistakes interacting with your patients - either forgetting to ask questions about their family history, drug use history, or past medical history, but the knowledge you gain from listening to their daily struggles such as remembering what medications to take, the financial difficulties in paying for their medications, and the difficult nature of changing their lifestyle will make you a well-rounded, more knowledgeable, and more compassionate health care provider that can truly make a difference in an individual's life.

Walter Kim

Written as M1 PCM Scholar



The PCM Scholars Program exposed me to the everyday concerns and worries of patients. I feel fortunate to have been able to play a role as a bridge between my continuity patient and her doctor (my preceptor).

There seem to be many times when a patient is not able to ask and get all their questions addressed during the clinic visit. I was glad that my patient felt comfortable enough with me to come to me with many of their questions after the actual visit. It was very gratifying to be appreciated, and I realized just how important it is for doctors to provide answers to patients and help allay their concerns.

There was a time when I received word from my preceptor that my continuity patient had been admitted into the ER for chest pains, and this shocked and worried me greatly. Thankfully, nothing was wrong with the patient, and she was able to return home. I was somewhat surprised to see the level of attachment I had acquired for this patient over such a short time. I can only begin to imagine the level of attachment that a primary care physician must have for their patients, many of whom they must have known for ten, twenty years.

Tiffany Kim

Written as M1 PCM Scholar

PCM has been a very rewarding experience. My patient is a very wonderful woman who despite her ailments tries her best to deal with her illnesses. Through our conversations, I have discovered many things about the importance of patient-physician relationship.

I have learned that...

...it is extremely important to build a relationship in which the physician and patient are mutual partners with the common goal of improving the patient's health.

...patients are not a set of symptoms or illnesses but rather, individuals who often face an array of difficulties in their day to day lives because of their ailments.

...patients need empathy and understanding when undergoing these struggles.

...it is our job as physicians to provide comfort and really listen to our patients.

...physicians often forget how chronic illness can take a toll on patients and how difficult it is for patients to make lifestyle adjustments necessary to treat their conditions.

...patients put in a lot of effort in order to comply with the regimen prescribed by physicians.

...it is very important for physicians to acquire feedback about treatment plans they prescribe for their patients.

...a good patient-physician relationship goes a long way toward increasing patients' compliance.

...physicians can make a positive impact in patients' lives daily if we establish a relationship based on trust and communication.

Overall, this program has opened up my eyes and reminded me of how our roles as future physicians are like no other.

Celeste Cruz

Written as M1 PCM Scholar





Learning from patients

Confidence: My First Afternoon in Clinic

“My name is Corey and I am a first year medical student at UIC,” I began nervously. I had never before uttered those words to a real patient, but I forced myself to continue: “I am learning how to take histories and would like to ask you a few questions before the doctor comes to find out how you’re doing and what brings you here today. Will that be okay?”

I am not sure why, but I half-expected the patient to laugh at me. Or at least roll her eyes and mutter “yeah right” under her breath. To my surprise, however, my ominous announcement about being a first-year medical student or learning how to take histories didn’t seem to faze her in the slightest. She shook my hand, smiled at me, and proceeded with a lengthy and very thorough discourse about some concerns regarding vaginal discharge.

After a few minutes of conversation, the interview was over. I survived and, most importantly, the patient seemed happy. I excused myself from the room, started to organize my notes so I could give an oral report to the attending, and then started to hope that the next patient history would go as smoothly.

Still, when entering the next exam room and standing before another patient, I felt a lot of my nervousness return. This time the patient was big and burly and would surely not take me seriously. I imagined that he had nerds like me for breakfast. I had visions of being demanded to leave the room and vultures swirling above the remains of my wounded pride.

But again, I introduced myself and the patient didn’t seem to have any objections. He opened up to me immediately and even asked me questions as if I were a real doctor. For a split second or two, I even felt like a real doctor. This interview concluded just as

successfully as the first and I was grinning from ear to ear before leaving the exam room.

Then came the third, fourth, fifth, sixth interviews of the afternoon. All of them turned out to be great experiences. Not only did I feel like I was able to relate to the patients, but I was left with a hunger to learn about their diagnoses. I couldn't wait to take an HPI from the next patient, but I was disappointed to learn that the day was over. I would have to wait until next time. It turns out that seeing patients, even as a first year medical student, isn't quite as scary as I thought it would be.

Corey J. Thompson

Written as M1 PCM Scholar



Big Red Stamp

[NONCOMPLIANT]

It's not my fault.
I did my part.
There's nothing more to do.
You're giving up?
Please help me, doc,
You've got to help me through!

You're noncompliant.
I just can't work
With all your extra needs.
Don't you see?
I'm short on cash
With all these mouths to feed.

You missed appointments,
Skipped your meds,
Never followed up.
He hits me
When I leave the house--
He might have beat me up.

You never listen
When I repeat
And gesture with my hands.
You don't speak
My language, doc,
I try to understand!

Appalling diet!
Outrageous weight!
Your children suffer, look!
Tortillas, rice,

Fried meats and beans
Are all I know to cook.

Your noncompliance
Makes me sick!
No more for me to do.
You know,
That's awfully funny, doc
...I'm feeling sickened too.

Lindsay Martin
Written as M1 PCM Scholar



“So, tell me your story...”

“So, tell me your story...” This is such a simple statement that one would probably take it for granted, right? I definitely did. Repeated consistently throughout my Patient-centered Medicine Scholars Program clinical visits, my preceptor has begun each patient interview with these words. Initially, I thought that it was just a more appropriate way of saying, “Tell me what is wrong with you.” Superficially, it is the initiation of a working diagnosis, yet the deeper context takes it to a much more powerful level. I did not process the underlying principle that it represented, let alone the effectiveness of the statement, until a few visits into my clinical experience. Having compared this opening statement with alternative approaches that I have myself either tried, or experienced as a patient, as well as those I have observed fellow colleagues attempt to use in the past several months, I realized its true power. The ideas of not only letting a patient tell you his or her story, but also truly listening, are the foundation of trust between a physician and a patient. Thus, I believe this to be the essence of patient-centered medicine in its simplest terms.

All patients have a story. While the main plot is the reason for which the patient is visiting the physician, the key characters and supplemental events shape the patient and give the physician the whole picture. Throughout my visits, I have found that patients are increasingly open and receptive when they are in control of their knowledge of the situation. In other words, firing questions at a patient without letting them establish a framework for the conversation can be frustrating and confusing. With that said, all physicians have the opportunity to listen to the story. However, many physicians choose not to listen. They choose not to engage with the patient.

Thus, they choose not to learn about the patient as a person rather than a diagnosis. Ultimately, the vital lesson, the humbling concept and the great realization that I have learned through patient-centered medicine is that the patient, rather than the physician, is the driver of a patient care team. The physician is along for the ride to listen to and engage in the stories and guide the patient towards a healthy lifestyle.

Samantha Knox

Written as M1 PCM Scholar

Since coming to medical school, a lot of my friends, particularly those who aren't in a field related to medicine have asked me "what it's like." "What it's like" is hard to sum up in a few words but usually I answer with the obvious: lots of stress, studying, long nights, exams, but good people. Though exciting, life in medical school can get a bit routine at times; and by no means do I mean routine to be synonymous with boring or mundane...but many mornings I'm sure we all find ourselves getting up because that's what we have to do, this is what we signed up for, and that's that.

It's ironic that in a field that is ostensibly as closely tied to the root of humanism through healing as one can imagine, we often have to pinch ourselves and ask "Am I still a person? Can I still feel? Have I gone numb yet?" And even more ironically I find it interesting that in this educational journey to learn how to heal others, I'm for the first time learning the importance of how to heal and take care of myself.

I think I best learned this lesson through my PCM patient who is a middle-aged woman suffering from chronic back pain. She sustained a herniated disc in her lumbar region about 5 years ago while at work and since then, her condition has worsened. Though she has had some physical therapy on and off, she has never had the time to fully recuperate from her injury as the financial restraints of her family require that she work and the only work she can do unfortunately involves manual labor. Her back pain continues to worsen and as I see her being referred for MRIs and to various specialists, part of me know all this is futile as she will continue to work because she must, and her back will get worse until she has no choice but to not work...the end.

But no, this isn't the end. During her second visit, we found out that she had never even asked her boss if she could be switched to lighter duty work. She was afraid this could cost her her job and didn't want to ask. After speaking with her and the attending

physician, I was finally able to convince her to let the physician write a note to her employer. This was small but it was a start. Unfortunately, we were not able to get her switched to lighter duty work but I feel that for the first time, my PCM patient saw that there may be other ways through her ailments besides just sucking it up and bearing it, or just going through the motions so to speak.

Knowing you have power and control in the direction your life goes is a great and powerful thing that I think we all too often forget. It's so easy to get stuck in a rut and forget why you're doing this thing you do everyday, which is why you need those reminders, those pats on the back, those words of encouragement to help you along the way. Much in the way that medical school has made me a better healer by helping me learn the importance of taking care of myself, I feel that the PCM program has likewise encouraged me through medical school during the toughest times by making me encourage my patients in their most needy hours.

Meenadchi Chelvakumar
Written as M1 PCM Scholar

Her nails are perfect—a work of art. They dart up to her eyes, brushing the reluctant tears away. Her makeup doesn't run. She brushes back her hair, but it is unnecessary: it will fall effortlessly back into place on its own. She turns her head back to me and lets the desperation flare briefly in her eyes.

"I haven't ever told anyone all of this."

As first-years, we lack the knowledge and reasoning capacity of our superiors. A clear path from symptom to diagnosis doesn't exist and we flounder through our interviews. But because of this and because our responsibilities lie mainly in learning, we have the time to talk.

It can sometimes feel delightfully subversive—stealing away time to let the patient talk without forcing structure onto the dialogue. It is not efficiency, but rather something bordering intimacy.

Of course it comes with frustrations. It can be therapeutic to have a place to release your stress, to unburden yourself and share your problems. But in the end I can't change the unemployment, solve the custody problems, or mend the longstanding rents in souls.

However, it is a privilege and one that all too soon will be curtailed and hemmed in by responsibilities. As we become the older students, become the attendings, it will be some new callow ear receiving these outpourings and we may receive only the abridgment.

Even now, we return too soon to the script, presenting the facts to the attending physician as he asks—*"Which of these problems can we actually solve?"*

It is a valid question and one that can assume gut-wrenching proportions. It is also the crux of patient-centered or humanistic medicine. Caring for the whole person will confront us over and over with our limitations as physicians. The limits on our time and resources do not limit the scope of problems and concerns patients can bring to us. It is an opportunity and an honor to be the recipient of so much private pain or joy and I hope to remember that. I want patient-centered medicine to continue to be a challenge to do better, a reminder of the complexities of experience, and the mysteries of humanity which drew me to medicine in the first place.

Anne Jennings

Written as M1 PCM Scholar



The first time I met with my patient, she recounted the struggles she faced with medical professionals at the hospitals she had previously visited. She described her frustrations with a system and individuals that provided medical services without encouraging patients to question the quality of their care.

This patient helped me uncover a new personal understanding of the distinction between medicine and healthcare.

Medicine is the practice of skills and techniques imparted to us by an ordained hierarchy of professionals and guidelines.

Providing healthcare to patients, however, involves a combination of biopsychosocial deconstruction, two-way conversations, and open communication among all levels of service providers.

Angel Desai

Written as M1 PCM Scholar

A New World

This year I had the privilege of interacting with a diverse group of patients. On several instances I was able to be directly involved in their care. For instance, I was able to be directly involved in their care a diverse group of patients. I was able to listen to lung and heart sounds, examine retinas, pack an abscess wound, and examine various skin conditions. One of the most rewarding experiences I had this year was when I listened to a fetal heart beat.

I also got a lot of practice taking a HPIs and complete patient histories. I learned that it's crucial to understand the patient as a whole person, before you can start to help them. On one occasion, while talking to a patient about her skin rash, I found that she had recently changed housing and was now living in a place that she felt was less sanitary. After some investigation, she told me that she remembered seeing black insects in her bedding on a few occasions. That day, she was treated with a scabies regimen and given instructions on how to sanitize her living quarters. From this experience I learned the value of taking the time to hear a patient's story. It's important to gather background information so that you can offer the best, and most informed, treatment plan for the patient.

Lastly, I have learned about the importance of being able to communicate with individuals from all walks of life.

Rashell Reynoso

Written as M1 PCM Scholar

Reflections on Lessons Learned from My Continuity Patient

Journal 1

Today I met my PCM patient. She has been diagnosed with hypercholesterolemia, osteoarthritis and hypertension. Also, my preceptor tells me she has been listening to voices and she is currently seeing a psychologist about this. The introduction was quick but I was able to talk to her privately for about 15 minutes. I could tell she was hesitant to talk about her problems, so we talked about her hobbies and how her week was going. She answered quickly and made long pauses in between sentences. She jumped from one topic to another, paused, stared at the wall and started a new topic. The conversation ended once my preceptor came into the room to begin his examination.

Journal 2

Today I called my patient. We talked about her day and she mentioned her family; she has a son and a daughter. I was glad to hear they live in the same apartment complex, although she lives separately, in her own apartment. When I asked if her family knew about the voices she replied back "Yes, but they don't understand. They don't believe these voices exist. No one does." I didn't know how to respond back. I knew she needed someone to listen, to take her seriously, to have empathy and to really feel what she is going through. I asked her "Do you want to talk about it?" but she simply said "I'll tell you about it later." After that, I tried to find common ground with her. I wanted to connect with her at some level. I was happy to find out we were both from the same state in Mexico and she talked about some areas I was familiar with. I can tell she feels more comfortable with me now; hopefully I can gain her trust.

Journal 3

Today is a very exciting day. My patient wants to see me. We are going out for lunch at a Mexican restaurant. I won't mention the voices today unless she wants to talk about it. I'll continue to focus on her weekly activities, her family and maybe talk about the medications she is taking, but only if she wants to talk about it. I just came back from lunch with her. I feel a lot closer to her today and I think we are really making progress. Even though her listening to voices was new to my preceptor, it wasn't new for her. She has been listening to

voices for 20 years now. She decided to tell me when they started and what they say. I was upset to hear all this. I couldn't even put myself in her situation. She is such a strong woman for keeping up with these voices and still managing to do her daily activities. Can you imagine listening to voices that degrade you, make fun of you and threaten you...all the time? The voices never stop harassing her. She feels overwhelmed and stressed and wonders why no one can get rid of them. She has an appointment with her psychologist and psychiatrist in one week and she wants me to accompany her.

Journal 4

After talking on the phone with my patient today, I feel very upset. Her feelings, her ideas, and her expectations from the visits and medications are all so complicated. She says these voices are very powerful and no one will ever get rid of them. She associates all her health problems to the voices. The high blood pressure, high cholesterol and arthritis are all caused by the voices. She associates the joint swelling not to arthritis but to the voices punishing her. She thinks the medication is useless and is thinking about quitting it. I don't know what to do, how can I help her understand that the medications will help her? I tried to explain to her how each medication works but it was useless; she thought it was controlled by the voices. My only response was "Talk to the doctor, but until then please keep taking them." I feel so incompetent.

Journal 5

Before entering the room where her psychiatrist was, she whispered "This one is kind of mean." I wasn't sure what that meant until I started listening to the psychiatrist. He started by asking her if the voices stopped. When she replied back with an example on how the voices haven't stopped he interrupted her and asked again "Have they stopped or not?" this time she just said no. He then asked "When was the last time you heard them?" she stated "Well, yesterday when..." and he replied "Ok, yesterday. I'm going to increase the dosage in your medication. Let me call your son." I looked at her; she was quiet and seemed upset. Doesn't he see that even his tone of voice has an impact on her? He came across as not being very caring and the appointment ended by him re-stating he increased the medication and she just nodded her head. Now, I really understand her dilemma. She is desperately seeking hope; she needs someone to instill hope in her and support her. Hope alone will give her the determination to recover more fully.

The physician should be teaching her about taking the medications and how they will stop these voices. We moved on to her psychologist appointment. As she spoke to her psychologist, I realized how important Patient-centered care is. She repeatedly talked about how her doctor (my preceptor) understands her and how she wishes other people understood her too. The psychologist expressed her concern and listened to her which helped her feel better.

Journal 6

Another appointment today... this time with my preceptor in Family Medicine. Throughout my experiences with my continuity patient, there was a consistent message about the importance of the patient-centered approach to care. Here, with my preceptor, I saw the meaning of it. He has established a relationship with her and she feels comfortable and trusts him. This patient-doctor duo can be developed into a healing relationship. My preceptor fulfilled the traditional role of being the expert in the pathophysiology of disease as well as an expert in the experience of illness. His occasional house calls to find out personal and family life have really made an impact on their relationship and on how she cares for her own health. With his encouragement and motivation, she complies with the treatment in hopes of getting better.

I realize now how imperative it is to understand the patient's disease and their experience of illness in the context of their life settings. A physician must consider the influence of family interactions and other relationships when planning treatment. Every person is unique and it is the person not the disease that has to be taken care of. By being able establish a relationship with the patient; a physician can have a direct influence on how a patient approaches their healthcare regimen. Also, the focus should be on the patient's needs rather than on the physician's desire for precision. I'm glad my patient is continuing treatment with the help of such an excellent and caring doctor. She told me she plans on going to the mental hospital for a couple of weeks. Until then, I will keep up with her by calling and supporting her through this difficult time in her life.

Yesenia Valdez

Written as M1 PCM Scholar

Ode to My Patient

I am standing before you
with my white coat shiny and new.
Insecurity masked by a pretense
that I could help take care of you.
Ok this is easy let's play doctor.
No that won't work I'm only an M1.
I think to myself who am I kidding?
How can I even help?
Weeks go by
and you talk
and I listen.
That's all I can do I guess.
Months go by
and we talk
and we listen.
"How's the job search going?
Oh and how are the new medications?"
I still wonder if I'll ever be a good doctor.
I still question.
But you are so kind and gracious
so I feel better.
And for a moment I don't question.

Melissa Preyss

Written as M1 PCM Scholar

Think from the patient's perspective—Look through the patient's eyes

When caring for patients, it is easy for the physician to become enthralled in challenges that these individuals pose and, at times, take their problems personally, become bothered, defensive, and agitated. Through working with my preceptor in the Patient-centered Medicine Scholars Program, I have learned that perspective, thinking about what the patient might be thinking, feeling, or desiring, is incredibly important in maintaining a healthy balance in the patient-doctor relationship. This balance varies from patient-to-patient, based upon the individual's needs and desires, yet when it is achieved, the most appropriate and beneficial care can be provided.

A returning patient presented to clinic with chronic aches and pains all over her body; she was wearing braces on both ankles and wrists to help alleviate the constant pain. In addition, she was struggling with intermittent pain in her abdomen and was concerned about having another heart attack. From speaking with this patient, it was clear that her illness consumes her life. She shared with the doctor a myriad of complaints in addition to those above, both physical and emotional, which were not easily addressed. After repeated explanations about possible solutions, the patient was still apprehensive and asking repetitive questions; she did not seem helped or eased by any remedy. This is a case where the doctor could become easily frustrated and have a challenging time interacting with the patient, especially when she is fast to contest any advice, yet my preceptor took a step back and looked at the situation from the patient's perspective. To deal with constant pain on a daily basis without alleviation must be incredibly challenging and disempowering. In the physician's last interaction with the patient, he put the ball in her court and gave her the power of when she wanted to return. After a challenging visit, she agreed and smiled, something she had not done during the entire visit. Some balance between providing and accepting care was achieved with the aid of sympathy and perspective.

I found this to be a touching experience and one that emphasizes the ability of doctors and patients to work together to achieve a beneficial relationship even in challenging situations.

Mara Motley

Written as M1 PCM Scholar

Transformation

In the three months since I met my patient, he has gone from denying his disease to taking an active role to battle its progression. My patient was diagnosed with diabetes last year and refused to accept the severity of his condition. In early January, the symptoms became more obvious to him and with the support of his wife, he reluctantly started treatment. However, that day he also learned that diabetes was not the only condition he faced. Many of his lab tests came back abnormal, making it necessary for him to see a number of specialists in addition to adopting life changes for his health.

Participating in his appointments has allowed to me see the type of care offered by several doctors and the change in attitude my patient has gone through. At times, it has also been overwhelming because of the concern that he was going to be diagnosed with more severe conditions. I would always ask myself before arriving to the clinic, "What can I do if he is told he has another condition in addition to his diabetes?" Fortunately, he has not received such news. So far my approach has been making sure that he comprehends the information given by his doctors, understands what the next step is and assisting him in navigating through his HMO.

Currently my patient is making an enormous effort to adopt healthy behaviors, such as exercising more often and eating a healthy diet. Whereas before he denied his illness, today he is the patient who tells the physician "You asked me to loose five pounds and I lost 10." The doctors are impressed with his cooperation and explained to him what a great accomplishment he has achieved. I could see how proud he was and how reassuring it was for him to hear those words.

Participating in the Patient-centered Medicine Scholars Program has been a great learning experience. I have observed my patient's transformation and the clinical care he has received from several practitioners. This has shown me the importance in continuing to educate and encourage our patients in order for them to understand and participate in the care they receive.

Yury Parra

Written as M1 PCM Scholar

Perspective: What is a patient?

Growing up, patients were part of the family business. They came into the office, and I saw them as people who needed help with their problems. They saw me as a kid.

In college, patients were the indigent villagers of the Community-Based Medicine Program in the Philippines. I saw them as victims of a faulty system, having to jump through hoops to get medical care they deserved. They saw me as someone whose small contributions could go a long way, whose outlook would forever be changed by the experience.

Our first patients in medical school were standardized. I saw them as teachers, experienced leaders who could guide us through a new and intimidating adventure. They saw us as novices, initiates into the medical society, impressionable students who needed feedback, advice, and encouragement.

Through PCM, my patient and I see each other as all of these. In many ways, we both embody every role as student, teacher, leader, advocate, and support. But she is more. She's a mother, grandmother, professional, and survivor. She is always learning, always teaching, and always proud to have her own medical student. As a patient with many physicians, she is patient, cooperative, and compliant. Though there are many obstacles, she perseveres. From her, I have learned more than just the workings of the medical system. I have learned what it is to be a 60-year-old student, a survivor of a difficult past, and a woman in charge of her future. I have learned from her as a person, and these lessons will undoubtedly stay with me throughout my medical career.

Mindy Guzman

Written as M1 PCM Scholar

Ode to the patient (in all of us)

It's time to take a vow
A vow for those who, in pain,
Come to us to in search of answers
that might help them understand.

In them, we should focus
Our attention, love, and senses
Despite those daily matters
That press us in the trenches.

And I know, we've all had them:
The test next day, the other waiting
But always think: if it was you,
Wouldn't you require excellence?

"What's wrong with me?" they ask
"I have to run some tests"
In the end, though, let their visit be
A lesson of love—relearned.

For them, we have studied,
The muscles, the bones, the brain
They already know we live for these moments,
Don't let them be in vain!

Yulieth Vento

Written as M1 PCM Scholar

Alberto

Before I first entered Alberto's room, everything I knew about him came from the patient chart: name, date of birth and diagnosis. I had no idea what his background was, what he did for a living, where he lived or even what he looked like. All I knew was that he had diabetes. However, during our first conversation in the clinic, I felt an instant connection between us. He talked about his recent diagnosis of diabetes and how he had very little idea of what this meant for him and more importantly, how it would affect him in the future. The whole situation was foreign to him because he was very health conscious, as he exercised regularly and ate healthy. He also filled me in with the other details of his life like how he works at a local youth center, lives in Pilsen and has a good friend that looks out for him. At the same time, he asked me about why I decided to go to medical school and what I hoped to pursue in the future. By the end of this encounter, I had learned a great deal about his side of the story and shared some of mine; however, I was still unsure of what this student-patient relationship would be like and how it would grow in the future.

Initially, whereas uncomfortable gaps filled my conversations with Alberto, I was now able to converse freely with him for hours. He became more comfortable sharing information about his past: he told me about his journey from Mexico to the United States, how he had to jump the fence in order to provide for his wife and two kids, he told me about the impoverished conditions he had to endure in Los Angeles, and how he finally made it to Chicago and took a job as a janitor so he could send money back to his family. More importantly, I began to understand his perspective on his diabetes and how it affected all aspects of his life. He had to start spending money on medications, which meant sending less to support his family. He also started noticing that he was unable to swim for as long as he normally could and this saddened him as swimming is main stress reliever. And because of the diabetes, he is now under

more stress to lead a healthy lifestyle and to make sure he keeps on top of his medications. Through getting to know these aspects of Alberto, I have felt my initial uncertainties about our relationship fade away and Alberto and I have become friends.

When I first entered the room, I knew Alberto as a diabetes patient; now I feel like I know him as a person. I wish that in the future, this experience will help me to get to know my patients just as well as Alberto and furthermore, that this will allow me to better understand my patient and their perspective of their disease.

Anubhav Kapoor

Written as M1 PCM Scholar



I was very excited to start working with my patient G.D., a male in his mid-40s who is HIV positive. Never having known anyone who has had HIV/AIDS, I really wanted to take this opportunity to learn about the disease and how it affects a person as a whole. After meeting with G.D., I learned about his career, personal life and his positive outlook on life. I read over his history and labs to get a better feel for what he has been through. Before knowing G.D. I did not realize how having HIV can cause or compound other health issues. So in addition to learning about his HIV, I had a chance to get to know about diverticulitis and hypertriglyceridemia.

Over the next few months, I kept in touch with him mostly through email and saw him at his appointments. It was a big concern of mine that he would be noncompliant and not show up. It was difficult to maintain contact in between appointments because he and I both have very busy schedules. There was a bit of a delay in terms of response time but he did always respond and make it to his appointments. Not only did I get to learn about a very interesting disease, I got to know my patient as a person. If I were to give any advice, I would say to not get discouraged if your patients are not responding to your calls or messages. Instead, keep trying to reach out to them, realizing that they have many things going on because of their condition. Knowing that you are there will make a difference

Candice Kim

Written as M1 PCM Scholar

Every Little Bit Counts...

It's a common cliché in our world today: "Every little bit counts." And like most other clichés, it tends to be rooted in a great deal of truth. Not every idea that benefits others has to be huge and far-reaching; rather, the best way to help someone can sometimes be found in the small, simple things you can do for them. Such has been my experience with the Patient-centered Medicine Scholars Program here at the University of Illinois-Chicago College of Medicine.

During my first year in PCM, I had the opportunity to work with a memorable patient—an elderly gentlemen whom I will refer to as Mr. E. Due to circumstances on which I will elaborate below, our relationship was quite short; yet, I was still able to walk away from the situation knowing that I had made a difference in his life.

Mr. E

Mr. E presented to the Family Medicine Clinic in February 2008 with severe swelling in his right leg and scrotum that had been present for a few months. The severity of the swelling and the length of time that had passed before Mr. E sought medical attention bewildered even me—an admittedly stubborn male that probably doesn't visit the doctor enough. In fact, it took continued coercion from his wife to finally get him into the clinic in the first place. As we talked to him, he revealed a history of Benign Prostate Hyperplasia, and he admitted that many of the urinary symptoms had returned. Speaking with the physician, she deemed it likely that his BPH was once again acting up.

His friendly demeanor and assumedly chronic condition made him a good candidate to be one of my continuity patients and graciously accepted my participation in his care. But as I interviewed him, we began to pick up more ominous details regarding his condition. In addition to the swelling, he had been losing a great deal of weight over these few months. His appetite was diminished and he said he felt sicker than he had during his previous presentation with BPH. Quickly, prostate cancer appeared much more likely than just the BPH. We made Mr. E an appointment with the urologist, and sent him off for labs.

Later that same night, I received a call from the physician telling me to pull up Mr. E's chart and look over the results, and they were not good: Mr. E had

signs of advanced prostate cancer, and was consequently going into renal failure. We needed to get him into the hospital right away, and the task of convincing a stubborn—and likely, scared—elderly gentleman to go to the hospital became my responsibility. This proved much more difficult than I had anticipated.

When I called him that evening, he seemed happy to hear my voice. We easily chatted and made small talk, but I quickly moved into the crux of the matter: His lab results were abnormal and we needed him to get to the hospital as soon as possible. Upon hearing this, he became much more passive and dismissive—he did not seem to accept the urgency of the matter. This cycle repeated many times over the next few days until he finally agreed to check himself into the hospital.

I did not know what to expect when I visited him at the hospital. In all honesty, I was concerned that my persistence had annoyed him to the point of not wanting to see me, but this did not prove to be the case. He retained the same friendly demeanor he had at the clinic, and he started telling me about the tests the doctors had run. Later, his wife pulled me aside to thank me for my perseverance: If I hadn't kept calling, she said, Mr. E likely would not have gone to the hospital.

And then it was done.

Looking over his chart a few days later, I saw that the tests confirmed the diagnosis of prostate cancer. I decided it would be a good time to go see him once again, hopefully to act as a calming force and help alleviate his fear. But then I read one small line at the end of his chart: "Patient has transferred care to Indianapolis to be closer to his family." He had already left UIH and taken the trip down to Indianapolis. I made one final phone call to wish him the best of luck, and that was the last I heard from him. And while I wish I could have been further involved in his care, I was happy that he'd be closer to his family. All I had been able to do for Mr. E was annoy him with repeated phone calls, but that may have just made the difference in his care.

Michael Kurzer

Written as Written as M2 PCM Scholar



Realizations

The delivery of quality medical care is something we all aspire to, but the definition of quality care varies. Taking a full history, making sure to order appropriate exams and following other standards of evidence-based medicine are often seen as all we can do in the 15 minutes we are allotted with patients. However, it is clear from my experience from working with patients in the clinic that doing so is the bare minimum of quality care. Patients leave the clinic and return to the same conditions that often exacerbate or cause the problems they came in with. Not fully addressing patients' needs often leads to problems such as missed appointments and failure to follow the plans management plans suggested by their doctors. Our challenge as students engaged in Patient-centered medicine is how to meet the needs of our patients appropriately without becoming full time doctors, social workers, nutritionists and planners. Just one of those roles can be overwhelming—trying to juggle them all for a clinic full of patients is not sustainable long term.

The problem seen at this level seems daunting, but that isn't necessarily the case. Often times taking a step back and establishing patients' most pressing needs can make simple solutions come to light, especially since many patients have the same needs. Patients I've spoken to that do not take their medications as prescribed often do so because they didn't understand the directions as clearly as they thought. Perhaps we can design better communication tools that help patients understand why they are taking certain drugs, how they work and how to take them. We can also think of ways that we can ask patients questions to make sure they aren't repeating what we've told them, but have genuinely understood the information. For patients that miss appointments, often times they do so because they have so many that it is overwhelming. If all a patient is coming in for is to check their blood pressure and have basic labs done, why not coordinate that with the other doctor they are seeing the week before or after so that visits aren't redundant? Why not design ways to help

patients be their own advocates and develop their own agency, instead of just helping shuffle them through the system?

Some students I've spoken to have said that solving patients' multiple problems is not their job—that is someone else's responsibility and their focus is on the patient when she or he is in their clinic. I understand that and I also sympathize with the argument that to focus so much on patient needs is draining and feels like a sure fire way to burn out. However, I believe that the solutions are not as complex as we think. We do not need to reinvent how health care is delivered. We need to think creatively and clearly about how to meet patient needs in novel ways that are effective, easily implementable and appropriate. We can only do so by engaging with our patients and helping them develop their own agency.

Tal Levin

Written as M1 PCM Scholar



Make It Personal

She walks in, hoping for a solution
 She walks out, in more pain and confusion.
 She yells “Stop it doc”,
 You makin’ me cry.
 She yells “Stop it system”,
 You makin’ me die.
 High BPs,
 Type II Diabetes,
 Challenging her health,
 Losing sight of herself.
 She faints.
 I faint.
 Make it personal.

Suga’

As sweet as her church choir songs,
 As sweet as her grandchildren,
 As sweet as her soap opera shows,
 As sweet as her smiling face,
 The glucometer reads 148.

The Dynamic Duo

The voice of the doctor
 Can be like needles—sharp, direct, and forceful.
 Change this and that,
 Don’t do this,
 But Do that.
 It can turn the patient off. Or on.
 The doctor can forget, it’s hard to change
 Or even worse, fix a broken record.
 But if the doctor and patient, tag-team like
 Batman and Robin, or

Peanut butter and Jelly, or
Mario and Luigi,
As partners,
Change can be,
Through the power of we.

P.S.

Please make it to your appointment. Be on time this time!

P.S. You have no car or money for the CTA.

Fix your diet!

P.S. There are no places for fresh produce.

Remember to take your medications!

P.S. You have 6 other medications to take and Medicaid won't pay for all of them.

Please try to exercise 30 minutes to an hour everyday!

P.S. The streets in your neighborhood are unsafe.

Improve your health!

P.S. You lack the resources.

Amish Desai

Written as M1 PCM Scholar

Please call me back

When I returned from the winter break, I called her. I had only met her once before, for the initial encounter, where I had learned about the intimate details of her life. The husband she had lost and the daughter who passed away too early. No parent should see her child go. Her working life at the insurance company, her children, grandchildren, and great grandchildren...it was a brief hour, but there was a tone of excitement that overlaid the conversation. It was to be the beginning of a relationship between a patient and a medical student. It had such high promise. I left that meeting with enthusiasm and hope.

It had been about a month since that initial visit had taken place and I had not spoken to her since. Over the winter break, the last thing I wanted to do was do anything related to school. I spent most days just resting and relaxing. I had planned to resume my duties as a student when I returned to school. So when I got back to campus, one of the first things I did was to call her. Bright eyed and well rested, I was actually quite excited to talk to her again.

It went to voice mail. I left a message. Told her I wanted to know how she was doing and was excited to see her on the next scheduled visit, which was in about a week. Asked her to please call me back when she had the chance. Couple of days later, I called her back. Again, the call went to voicemail. I left her a second message. I called her again later that same day. No answer and no return calls. It went on for about five days, over 10 calls that were unreturned. I was beginning to get worried. Something must have happened to her over the break. It had been over a month since I had last spoken to her. Worried and anxious, I called the preceptor. Left him a message. Asked him to please call me back.

And he did, within a few minutes. He told me he had talked to her. He was aware that I had been calling her. He was aware that she

was not answering my calls or returning them. He told me she was upset. He told me she took this relationship seriously and that she expected more from me. I was surprised to hear that she was purposely not returning my calls. Hearing that, I was a bit upset myself, I had been on vacation, I am only a student, I had called her so many times, I was worried for her...

But after a short moment, I began to wrap my head around what had happened. Here was the patient, who had decided to invest her time and so much of her personal life to a stranger, who had promised to be there for her. And after one heart pouring session, there had been an abrupt silence. Apparently she had called me over the winter break, but unfortunately I did not receive that call and was not aware of it. She must have felt neglected. She must have felt like she was lied to.

I will never forget this experience. I will always remember that patients can be in need even when I am on vacation. I will always remember how much the patients put their trust in their physicians and remember the vulnerability that is extended to their doctor. When I joined the Patient-centered Medicine Program, my desire was to learn from the very earliest part of my medical career the right way to interact with the patients. And I think I am beginning to get exactly that. One of the first lessons: healthcare doesn't run on doctors' schedules, it runs on the patients'.

Richard Keyme

Written as M1 PCM Scholar

Incentive to be Better

It's not easy to be on patient side,
To find a health care provider in whom to confide.
To feel safe putting your life in another's hands,
For your health care problems to be the center of all your plans.

It's difficult to cope when your pain is constantly a nine,
But you need to have strength for your family and seem like you're fine.

When medical problems get in the way,
Of accomplishing the goals you set for the day.

When going to the doctor is a normal part of your week,
And your numerous medicines make you feel weak.
Life isn't turning out the way you thought it would,
But you make the best out of it because you feel that you should.

It's inspiring to see a patient still optimistic,
About a life that is extremely far from simplistic.
To take control of their health and make of it the best,
It really puts stereotypes about uncompliant patients to the test.

From the medical student perspective it's so good to see,
Patients involved in their health to the utmost degree—
It shows that a difference can be made after all,
Working with the patient to suit their needs is essential in the long haul.

Olga Kantor

Written as M1 PCM Scholar

In the sick room, ten cents' worth of human understanding equals ten dollars' worth of medical science.—Martin H. Fischer

à nuit, tous les chats sont gris (nighttime erases the differences between things).
—Fred Stonehouse, *Kilroy-Coq-à-l'Âne*, 1999.

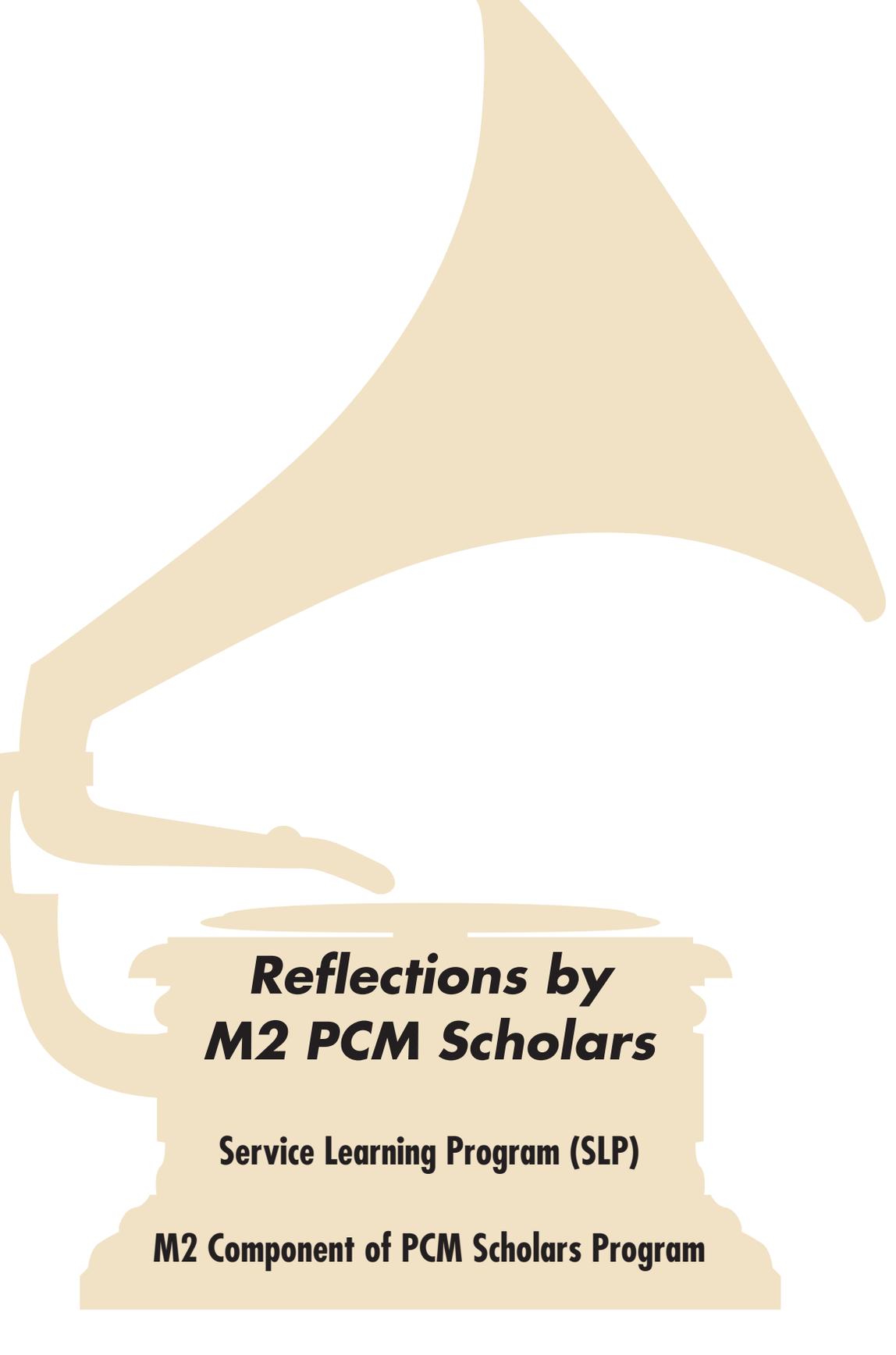
So young
Amongst the beeps
He works to sleep
Breaths
Hoarse,
Drowning

Although surrounded
He wanders
But one voice
Gives him the lawyer
and lungs.
So he can speak.

She is patient
In her dark red dress
She sits in her kitchen
But wrapped in its warmth
She burns
And sweats

Her grimace
He's stuck in the doorway
Outside
It's green, too bright
Voices are firm but strong
They take his hand and
Barefoot
He goes.
Hello.
And Happy Birthday.

Julie Tsay
Written as M1 PCM Scholar



***Reflections by
M2 PCM Scholars***

Service Learning Program (SLP)

M2 Component of PCM Scholars Program



domestic violence

From the Woman Within

You see my smile, poise and grace
But my feelings aren't just on my face.
I want to be normal and just fit in,
But I can't with my burden; it's under my skin.
I come to you because I am sick
The cause of my illness, there's too many to pick.
If you'd ask me about the relationship I'm in
You'd find out so much, you'd know where to begin.
You'd learn of the violence, whether actions or words,
And all of the terrible things that I've heard.
Your mind would be racing, wondering what you could do
When all that I need is to feel respected by you.
Your smile, compassion and listening ear
Would mean so much, and I know it's sincere.
You have to know that I want things to change
But there may be things that I need to arrange.
Continue to support me for as long as I take
It is a big task; the new life I must make.
Also be patient with other women like me
Who aren't quite ready to disclose their story.
Just be there to listen and empower them too
Because someday when they're ready, they'll come to you too.
Domestic violence is something I wish wasn't here
But as long as it is, we must help those in fear.
Give us the resources to stand on our own
And continue to be the great person you've known.

Bethany Schmidt

Written as M2 PCM Scholar

STRENGTH

All you see at first is a young frail little woman
Eager to talk and put her life together again
A young woman with so much incredible history
A story wrapped deep in experiences of many
Only 32 years old and has experienced so much
Lived to help those she loved yet has not gone untouched
Abused by the man she felt so close to
Only for him to do things to her that she can never undo
A past that you must try your hardest to unwrap
With compassion and care not to yourself fill any gap
She complains of ailments that on the surface seem minor
But when you delve deep, these symptoms you cannot ignore
A history of left sided tremor, no appetite, fatigue, and weight loss
As you listen to her story you make the connection across
A connection between her symptoms and her terrible abuse
You see the look in her eyes when you explain her situation
That her past trauma may have caused her present condition
As you continue your interview you uncover more of her history
More times of struggle, hardship, and a will that is hard to believe
A loving mother of three beautiful children
All of whom for seven years she had not forgotten
When she lived in her car to try to get them back
After her husband conspired a story to show her lack
Her "lack" of ability to be a good mother
His way of hurting her and controlling her unlike any other
Eventually she figured out how to get into the groove
A way to push forward and make a steadfast move
The momentum to fight back and show who she can be
The amazing woman and mother who is finally free
Free of the darkness that loomed over her for so long
She is now ready to bond with her children and not do them any wrong
After all she has been through she is ready to live

Live life to the fullest and show all that she can give
Help all the others who are hurt by their loved ones same as she
To educate students like me and show us how to be
Be the physicians that patients can turn to in their great time of need
To help them feel safe in their lives and finally be freed.
As I listen to her amazing story it becomes clear to me
I am in the presence of someone stronger than I could ever be
An amazing woman that even after so long
Has the strength and endurance to go on
And change her life into what she wants it be
As I promise to help her with all that she needs
I make clear to her all the valuable things that she has taught me
We exchange information in hope of a future appointment
Ending our time together with a hug and a smile, neither with
disappointment
A thank you from one to the other we both exchanged
All the while knowing how much we both have gained.
The future looks bright for this wonderful lady,
I am excited to be a part of her upcoming journey.

Krista Childress
Written as M2 PCM Scholar

One “Simple” Question

She seemed like a normal, everyday type of woman. Walking into the clinic, you know she is old enough to have had some hardships in life and important life experiences. She is not very talkative, but instead, she is quiet and solemn. It is your first time seeing this patient, so being the competent physician you understand that taking a detailed history of this patient is key to your first encounter.

You easily get those routine questions out of the way. “Where’s the pain located?” “How long have you had the pain?” “Do you have any idea what may have caused the pain?” The answer to this last question is “no” and the woman states that she would just like medicine to lessen this constant pelvic pain she has been experiencing. You whiz through the history of present illness, the past medical history, and the family history. No problem. You were trained well in medical school to ask these essentials.

The same as you were trained for social history. “Are you married? Or do you have a boyfriend?” She answered in the affirmative. She has been married now for the last twenty years. She answers each question with short, concise answers. She does not offer additional information. You as her physician become curious about her home life. Though the question you want to ask may make you hesitant and nervous of the response, you feel you must. “Does your husband ever hurt you physically, emotionally, or otherwise?”

She just stares at you. You are afraid of her response. Will she be insulted, angry, or even scared? Finally she tells you that no one has ever asked her that question before. Not the ER doctor she has seen for broken bones and bruises. Not the other doctors she has seen for various other reasons. She is astonished. And suddenly, this quiet woman is not so quiet anymore. She explains to you the situations of her life. She talks of her husband’s bad temper and foul mouth. For twenty years she has waited to talk to someone

about it and now with one question it seems she has finally been able to let out her frustrations about her life and most of her worries.

You sit with her for longer than expected. Your other patients are waiting, but you want to make sure that this woman gets all the comfort and help she can from you. You speak to her of agencies and hotlines, but most importantly you let her know that you are her advocate, always there to help her when she needs. Her look of relief and appreciation is all you need to re-affirm your reasoning for screening for domestic violence and ultimately becoming a physician.

Jennifer Lo

Written as M2 PCM Scholar



The first two years of medical school are all about learning by reading and memorizing. We read books, lecture notes, reviews, and study guides; everything that we need to know we can find printed on a page somewhere. It is safe and comfortable to simply flip to the index in the back of a book and find the page number for the information that we are looking to find. We turn to that page, learn what it says, and memorize it for the next exam. It makes sense then, that when we learn to take a patient history, we follow a script. We learn what questions we are supposed to ask in which order and even how to word the questions with which we struggle. We are at ease asking questions that are printed on a card that we can keep in our pocket and reference when we get confused. Printed words that we can memorize are our comfort zone.

My experience in SLP has emphasized the importance of stepping outside of the comfort zone on the bookshelf and being able to learn from other people. There is no book that can prepare us for the first time that a patient is willing to share her life story of pain and abuse. Nothing we can read can teach us how to develop the trust and understanding needed for a patient to feel comfortable sharing their most intimate stories with a near stranger. Many students want someone to spell it out for them, to tell them the words to say and the questions to ask. What I learned is that it not as simple as reading off of a script or memorizing what parts there are to taking a history. There is more to it than merely asking questions to get to the root of the physical problem. All patients, but particularly those who are victims of domestic violence, need us to look beyond the words that we have memorized and listen to the words that they are speaking to us. For many of these women, the most important thing that we can do is not to run through our scripts in order to provide physical treatment for their injuries but instead to offer an empathetic and listening ear. It is one thing to learn that abusers try to control their victims by physically and socially isolating and another thing altogether to be sitting next to your patient while she cries as she tells you everything that has

been weighing her down that she cannot share with anyone else. All of the statistics and “proper” questions that we learn will not help when the woman across the table asks how she is supposed to find a job to provide food for her three children at home when she cannot afford childcare. There is no book that can teach us how to react when a woman finally divulges that her husband of fifty years has been hurting her. These are not answers that we can learn from a book.

How to learn from and connect to another human being in a way that is supportive and caring is the most important thing that I have learned from SLP. My patient is not worried about getting her aching knee treated right away; she wants someone to listen to and validate her experiences. She wants her doctor to understand that she is suffering from more than just the physical ailments that her abusive ex-husband left her. She is lonely, depressed, overwhelmed, and needs someone who will pay attention to the words and treat her as a human being and not just a chief complaint. It is not always easy to put the books and the facts aside to connect to another person, but it is just as much a part of our jobs as all of the information that we spend so much time memorizing. If we could put even a fraction of the effort that we put into learning every word on every assigned page of reading into learning how to treat our patients as people, we will be much better doctors for it. My patient has taught me that I can do so much for my patients by just listening to what they are saying and responding in a thoughtful and compassionate way, and I will forever be grateful to her for taking the time to teach me.

Laura A. Niiro

Written as M2 PCM Scholar

The goal of the Service Learning Program is to empower underserved patients by helping them gain access and establish continuity of care. In this aspect, I found that my endeavors were unsuccessful I have been unable to get my patient to the clinic after multiple phone calls and a couple of appointments my patient missed. However, even in failure, I have discovered that I gained much from my experience.

As doctors, we expect patients to come to us. We hand them our card and tell them to give us a call us when they need. When I met my patient, I had this same mentality, believing my patient would contact me as soon as possible to take care of her medical needs. Unfortunately, this was not the case. I wasted a month waiting for my patient to call me and then another month just trying to get her phone number through the agency. This extended gap of time between communications most likely deteriorated the relationship that we had created during our first meeting. It is important to remember that individuals are hesitant to trust others with their personal life. This is even more of a problem with underserved populations, such as victims of intimate partner violence, because they often feel undeservedly ashamed of the events that have occurred in their personal lives. Contacting the patient first relieves the patient of the burden of having to initiate communication. Furthermore, it shows the patient that you are committed to maintaining the relationship you started.

Beyond medical student blunder, there are regrettably many other obstacles to accessing healthcare. For the immigrant population, the language barrier becomes an issue. Immigrant patients feel frustrated at their inability to convey important health information to their physicians. This makes it difficult to create a good doctor-patient relationship. This emphasizes the diversity needed in the medical profession so that we can properly care for our diverse patient population. To find a doctor they are comfortable talking to, patients will travel long distances. Patients frequently need to use public transportation, yielding transit times of an hour or more each way. The inconveniences of travel keep many patients from seeing their physicians unless it is absolutely necessary, reducing the amount of preventive interventions that can be done.

We are most likely all aware of how medical bills can be a hindrance to obtaining healthcare, but we often neglect the less explicit costs. The opportunity costs for going to the doctor's office can be astronomical for people in underserved, poor populations. Seeing the doctor means losing much needed wages in addition to medical costs. For some that don't have the advantage of sick days, it could also mean losing their jobs, especially in today's volatile economy. In the case of stay-at-home mothers, it may mean spending money on babysitters or leaving their children alone at home, which they may be unwilling to do. Once we get them into the office, we forget about the costs of administering healthcare, particularly with medications. It is easy for doctors to memorize what drug regimen is used for a particular illness and prescribe at will. However, there are often overlooked generic equivalents that are much cheaper. Unsurprisingly, patient compliance to medication usage increases when they can actually afford their medications.

Even with my better understanding of the obstacles to healthcare, I believe the greatest thing that I've gained from the SLP is an increased awareness of intimate partner violence. I am astonished at the prevalence of it in our general population. Yet, what surprises me more is the similarity of symptoms experienced by the victims. Victims don't just show up with bruises and hurt feelings, but with chronic pain, tension headaches, and deep depression. Of course, not everybody with these symptoms is a victim of intimate partner violence. However, with the tool of indiscriminate domestic violence screening, I will hopefully be able to identify victims regardless of what symptoms they may present with.

Although I failed to empower my patient, the Service Learning project has succeeded in empowering me. I feel as if I have gained experiences that help me become more of an asset to my patients. With greater insight into patient obstacles, I can assist others to steer around the barriers to receive the care that they need. Furthermore, I hope that one day my knowledge of intimate partner violence will be able to help put victims on a road to recovery.

Esther Ji Yeon Lee

Written as M2 PCM Scholar

She was just your typical young woman. I would not have noticed her in a crowd. She bore no scars on her face, she was not undernourished. Her pain was internal. She smiled at me and offered me eye contact with ease. "I wish I had a brain tumor." But why? Do you wish you were no longer living? "No. I want to live. I want to love. I want to be loved, and I want to belong." Such everyday thoughts from a woman who just a few years ago was a girl. I could relate to every one of her wishes. Her strength was awe inspiring, her ability to get up every day and face a world that had brought her pain and loss was humbling. Her family removed from her life, her son dead, 2 marriages filled with violence, her future uncertain. And yet her words were simple, and her needs straightforward. A little comfort, given woman to-woman, a little assurance and friendship. Where I expected weakness, there was courage, and where I anticipated hopelessness there was yearning, and where I was sure I would be worthless I found I had something to offer a woman in pain.

Geena Jester

Written as M2 PCM Scholar

This year began with our group, which focused on domestic violence, going around the table and explaining what drew us to work with these clients in particular. The reasons I chose then are very different from what I now know, have experienced, and learned from working with my own patient.

Domestic violence is much less black and white than I previously thought. Issues of immigration status, past criminal history, drug use, infidelity, and their own past acts of violence may keep some women and men from acknowledging that they have a choice to leave an abusive relationship.

My own client experienced much more emotional abuse and neglect than physical violence, and the issues I mentioned previously had clouded the relationship to the point where she felt the guilt that should have belonged more with her abuser.

Most of her health problems stem from depression and ongoing guilt, and that has been the hardest thing for her to begin talking about. Convincing her that she has to forgive herself enough to realize she does not deserve poor treatment will be a long process, one that she can hopefully see through. Her situation has shown me just how complex domestic violence can become, and that her health, not just her physical safety, has suffered most.

Emily Newman

Written as M2 PCM Scholar



You opened your life for me to learn. Your wounds for me to witness. Your heart that made me cry. Thank you. Esperanza, although this is not your real name, is what I call you because knowing you brings hope. In spite of your pain. Though leaving your support system in Mexico to be with your partner in the Midwest. Then being stabbed over fifteen times by him. After leaving your ex-partner and being homeless in the park. Enduring another wound after losing communication with your oldest son after he was deported back to Mexico. Now you are sleeping on the floor at a friend's apartment. Regardless of these many horrific experiences, your spirit fights to live. Dearest Esperanza, we tried to get you medical treatment. But this was proven difficult since the American Society restricts access to people in poverty (paradoxically, we all know these are the people who most need care). Community clinics need relentless support. Our work underscored this realization. At the same time, Esperanza, this brings me hope. Hope knowing there are like-minded colleagues, present and future, whose life mission is to provide compassionate care to you and our communities. Together, you, them and me. Collectively, we will work to improve our system of support. One day, we will surround ourselves with safety and reliability. We will surround ourselves with love.

Peter Ureste

Written as M2 PCM Scholar

Ember

like an ember
born in a blaze
this one, of pain and confusion
of violence, addiction
anger and chaos

there she sat
quiet, watching
softly glowing with potential to
burn

a fire, like the one before?
a life, like that she's lived?
a world, full of only the same?
or. . .

burn bright, fragile ember
burn with a fire of hope
of laughter, of success
pride and joy
bravery
safety

set your world to flame!

i am only honored
to add my wisp of breath
and to have ever felt your warmth

Lauren Kendall

Written as M2 PCM Scholar



HIV/AIDS

The White Coat

Eyes searching and scared
Look deep into the eyes of another
Unsure of what is ahead
Control stripped away, undone

Hiding behind a big white coat
I scramble for words to say
Shall I protect myself from the pain
Or give myself by saying nothing

Your eyes speak louder than a diagnosis
Your words softer than a tear
Hope a whisper, truth a song
You are not an illness but mind, body and soul
Of infinite value regardless of what they say
Hearing your story what a treasure to me

Could it be that life is not
Defined by what we do
But when we choose to listen
We choose to love

Who we are when we face each other
Speaks louder than any accolade

Jeffrey Larson
Written as M2 PCM Scholar

Into the Swamp...

I find it very difficult to write this paper. I want to tell you about my experiences trying to make a difference in the lives of thirty something people living with HIV on the West side of Chicago. At the same time I want to highlight the need for change in a system that really is no system at all. I do not have the time, or really much of a desire, to discuss the various solutions that have been proposed, or should be proposed. My goal is more to open your eyes to look at the swamp called health care that we and our patients wade through every day. The reality is that most of us would be content to build bridges over the swamp and not look down at the problems that face the sickest and the poorest people (these are so often the same). So come wade through the mire with me.

Earlier this year the HIV/AIDS student group met the people of AIDS Care Inc. in the North Lawndale community. We sat down and discussed with the clients that lived in this housing facility their most pressing issues. I was amazed at how open and honest they were with us, complete strangers, who, frankly, had little if anything in common with them. Our group did not have much to offer to the clients, but we recorded the issues that they wanted addressed with a promise to return with more information and whatever help we could offer. Throughout the discussion, one topic was brought up over and over again by several of the patients: access to special services like vision and dental care. In addition to this discussion, we were introduced briefly to how funding through the Ryan White CARE Act of the federal government is intended to support care for HIV/AIDS patients.. The idea I left with was that there are monies available to HIV patients to provide for their basic health care, housing, and social support needs.

Fast forward to a few weeks later when my patient and I met one-on-one to discuss her individual health issues/concerns/needs. Among them was affordable dental care closer to where she lives. I was now "assigned," if you will, to doing some detective work and helping to find more information for both my patient, and hopefully everyone living at AIDS Care. I began by calling a lady at Midwest AIDS Training and Education Center (MATEC) and leaving messages for her. Thankfully she called back and gave me a few leads on where I could find more information. The main source for the rest of my pursuit was Test Positive Awareness Network (tpan.com), which has a database of supposedly Ryan White funded programs for HIV+ patients. In this database is a list of dental services organized by sections of the city. My

search now narrowed to a list of twenty or so agencies that claimed to offer dental care to people living with HIV.

I called all these agencies. None of them answered my call. I got really good at my “sales pitch” message and I made sure to leave my phone number at least twice, hoping they would give me a call back. After making my way through the list, I also tried emailing the few that had email addresses listed. I tried several more times over the next few days to contact these agencies. At the same time I was researching them on their websites. Many of them sounded really good and really promising. Eventually I started to reach people, and one place even returned my phone call. Sadly, when I did get to talk to someone, they either gave me someone else’s number (why is that number listed in the directory if it isn’t the number I really needed to call?) or told me they no longer take Ryan White patients or that my patients don’t qualify because they are not homeless or aren’t substance abusers. Now, I hope you can see the frustration I was experiencing, but I want to take a brief time out to make a point clear. My frustration was focused at the people who didn’t answer my calls or who didn’t give me the answer I wanted. I realize now that I shouldn’t be frustrated with them. The problem of them being so busy that they could not answer calls or that they were unable to take Ryan White patients, or that they could only provide care to certain people was not the fault of the people I was talking to individually. The fault is also not our government’s, in my opinion. It’s not the bureaucracy and politics that we need to blame. The fault is our own, both individually as future physicians and collectively as the American people. We can blame everyone but ourselves for years, and nothing will change. It is only when we take responsibility for the way things are in our world that we can make a difference.

Back to my frustrating quest for vision and dental care for AIDS Care patients. Let me sum up the next two weeks. I eventually found one decent lead for dental care that is located near AIDS Care. I also found a potential place where AIDS Care patients could get vision care for an affordable price. I discovered in this process that Ryan White funds do not cover getting what most people think of as vision care – getting your vision checked and getting an eyeglass prescription if needed. I compiled all the information that I had found into a little flyer and had it printed out for the patients at AIDS Care and took it with me when we returned to discuss the topics they had brought up in our initial meeting.

What was done with that information, I do not know. I hope that some have used it to get care. For me, the process was disappointing. I put a lot of work into it. I waded through the muck to help patients find a possible path to vision and dental care, however, I don't know if the patients were actually able to receive the kind of care that they needed. One thing I did learn clearly is that the health care system is so complicated, fragmented, and difficult for anyone to navigate that even available resources, though limited, are often impossible to utilize.

That leads me back to what I want to discuss with myself out loud to you. Hopefully, what I did was helpful. But I feel that what I did was not enough. At the beginning I said I was in a difficult situation writing this paper. The difficulty is this: our health care system is a muddy, icky mess. How should it be fixed? Certainly this problem is not more complex or insurmountable than the multitude of problems our historical leaders and the American people have taken on and overcome throughout the history of our nation.

I would love to have written an essay about what the "ideal" health care system should look like. Instead, almost against my will, I wrote about the frustrations that have led me to a true awareness, knowing that without you having actually experienced it, you may not quite catch the stinking scent of the swamp. My hope is that this will dovetail with your own experience in some completely different scenario, and ignite in you a sense of duty to be more than a not-so-innocent bystander. We as physicians or future physicians have a huge part to play if this job is to get done. We cannot do it without our patients and the leaders of this country, certainly, but they also can't do it without us. What the outcome will be (what it will look like after the swamp is gone) we don't know exactly, and it probably won't look exactly like what you or I envision. Regardless of what comes next, the only way we'll get out of the mire is if you and I get down into the muck, start draining the swamp, and filling it in with good soil so that it can be remade entirely.

Nate Copeland

Written as M2 PCM Scholar

How Can We Make a Difference?

She needed to lose weight and get back to work. He wasn't concerned about the risks of diabetes. She was scared about her Chlamydia and only connected through text messages. He didn't want information about his HIV. These are the diverse faces and unique circumstances of the patients I interacted with over the past two years in my SLP and PCM experiences. I wish I could say that they were success stories: that she lost weight, that he managed his diabetes through lifestyle modifications, that she took the initiative to protect herself, and that he agreed to start medication. But that is not the case. I was an idealist. I could change the world. I thought people wanted the best for themselves, and I would be the facilitator of that goal. The real stories were different.

She didn't want to bother losing weight or going back to work even though her ulcer was healed and her life at 33 was just beginning. Her barrier wasn't access or cost; she owned a treadmill and ordered pizza everyday. Ten minutes a day, I pleaded, with weekly follow-up phone reminders and encouragements. But the weight continued to increase with growing complications, and she never felt like returning to work and getting off disability. The main request was for pain control, filling prescriptions for Vicodin at multiple pharmacies—inconsistent stories of pain for the ulcer that was almost healed. Then she requested not to be my patient anymore; I was no longer allowed to go to her appointments.

He regularly checked his sugars and put them into an excel spreadsheet complete with graphs, averages, and standard deviations. He recorded times and meals, and he always took his medications. He knew his sugars weren't under control, but he didn't want to put any effort into changing them. He could see evidence of how inadvertent exercise had drastically improved his levels, but the motivation wasn't there. What about fixing your stationary bike, walking around the block, getting a gym membership, attending a nutrition consultation or a cooking class? He never followed through with his nutritionist referrals, and besides, he didn't do the cooking. He preferred e-mails, which I used as a mechanism for patient education. The risks of long-standing diabetes are many, including stroke; you're too young to worry about that. Only lifestyle modifications or starting insulin can prevent them at this point. Thanks, he said, but don't worry about me; I'm not worried. I'm not afraid of insulin. And all the advice from my preceptor and from me fell onto a deaf ear.

She was part of an IUD study that her mom encouraged her to do for the free birth control. Then she started bleeding heavily and scheduled an appointment, but she didn't show. I tried to track her down by calling all the phone numbers we had. I tried to get more information through phone messages and e-mail. She couldn't afford the \$15 co-pay. We reduced it to \$2, but she still wouldn't come. We asked her to stop by for a free urine screen. Soon after I got a text: what were the results? She was concerned. If I respond, is there legal responsibility attached to a text message? She had Chlamydia. We gave her antibiotics, but she didn't take them. We gave her another type with a single dose, and the bleeding finally stopped, four months later. Had she acquired PID? Whose fault was it? I set it up for her to receive a free HPV vaccine, but she didn't follow through despite the reminders.

I only met him at the initial site visit. He was scared about his HIV, but he didn't want to come to the clinic. He didn't want to take medication. He gave a wrong phone number intentionally. He was lost to me before a relationship could start.

I wanted one, just one, to be a success story. You can lead a horse to water, but if he doesn't want to drink, he won't. These patient experiences drained me emotionally because I cared and invested so much. If I couldn't manage four patients, how can I manage a practice of hundreds of patients? I'm not serving humankind; I'm nagging. I make people uncomfortable because that's what doctors do. Doctors are babysitters, required to find out why patients didn't show and always accommodate. For a missed haircut, you still have to pay. For a missed doctor's appointment, the providers have to pay. Maybe health isn't what everyone desires. Maybe there are secondary gains to being sick; maybe it's too much work. But why should I have to work hard to pay for their insurance if they don't want what it can give them? Why should I have to responsibly care for my body when there are no repercussions for the easy way of fast food and sedentary lifestyles because the safety net of advanced healthcare and insurance will cover them? But what if we didn't live in America?

Ashley Styczynski

Written as M2 PCM Scholar

While working with and listening to different patients with HIV/AIDS over the course of the year, I have been able to learn much. However, one particular message has been repeated again and again. This message is that medical practitioners should never presume to fully understand the situation of any patient with HIV/AIDS. Clinicians, no matter how many people with whom they have spoken, or how many patients they have treated, or how many journals they have read on HIV, can never fully understand what any patient with HIV has experienced.

Many clinicians know well that HIV can affect every part of a person's life. Myriad changes can affect a person's body, whether from the virus itself or from the antiretroviral medications. The uncertainty and fear that comes with having the virus can affect a person's mental and emotional state. The stigma that surrounds HIV status can change how someone interacts with society, even during their daily activities. Even a person's faith can be altered in various ways because of HIV.

However, even the most empathic clinician cannot understand the endless ways in which these changes can manifest, or the true intensity of these changes, or the net effect of these changes on a person's well-being and life experiences.

This is why, with this specific patient population, it is extremely important to work with the patient. A clinician must do her or his best to understand each patient's unique situation in order to find the most appropriate course of actions in both treatment and lifestyle decisions. Listening to the patient and letting them teach you about their own experience rather than assuming to even begin to understand their situation is the only way to provide ideal care to patients with HIV.

Blake Fleeman

Written as M2 PCM Scholar

If you had asked me in August what I expected from the PCM-SLP program I would have told you that it is an opportunity to build a relationship with a patient and learn about the patient's personal experience with the healthcare system. Of course, that is the basis of what PCM is about, but I've gotten so much more from this year than I ever could have imagined.

PCM has truly enriched my medical school experience and given me an opportunity to grow not only as a student but also as a person. I think the greatest thing about the program is that it has opened my eyes and made me realize how important it is to always take a step back and think about how I am practicing medicine. My perspectives will always affect my interactions with patients, but this year has taught me to keep an open mind, to always listen to what my patients are saying and to try to put my perspectives aside and do what is in the best interest of the patient. These things seem obvious and as medical students we always discuss ways to do this, but PCM has been an opportunity to practice those things we've talked about. I feel extremely enriched by this experience and the opportunities I've had to share what I've learned with my fellow PCM participants and faculty.

Jamie Brewer

Written as M2 PCM Scholar

My prior conception of Patient-centered medicine seemed quite obvious. The patient would be the center of the complete medical experience. Their health concerns, thoughts, and needs would be met with the highest priority. And the medical team would assure each and every patient understood this priority. Throughout this program, I have learned that the patients, although initially reticent, truly blossom when they understand these simple goals. The patient begins revealing often sensitive and personal stories about their lives and experiences all the while enriching the experience for us as students. As the “student doctor” you instantly understand that you are just that....a student. A student to the medical work up, to the patient and their insights, and in this process you continue to build upon each visit.

This has been a unique opportunity to not only learn about the pathophysiology of disease, signs and symptoms, health care management, but to truly connect with a patient at the infancy of our careers.

Lauren Taglia

Written as M2 PCM Scholar



Yoga

Hands to heart center.

Inhale.

Enter your body.

Cleanse. Come to life.

Exhale.

Stand still. Steady. Strong.

Inhale.

Animate the dark corners inside.

Exhale.

Press your blistered palms together.

Inhale.

Lift the arms that build and bleed.

Exhale. Hacia abajo.

Fold down to the earth.

Stretch the spine that bends over the harvest.

Inhale. Para arriba.

Lift open the heart chakra where the baby sleeps.

Turn your face to the sky.

Release your jaw. Forgive him.

Exhale. Down.

Spread your toes wide.

Gaze at the feet that carried you north.

Bendígalos.

Inhale. Up.
Tuck your tail. Feel Mula Bunda, root lock.
The tiny place that died in the factory.

Slow, slow exhale.

Come to the ground.
Feel its support.
Suspira.
Savasana.
Corpse pose.
Let it fall away.

Suspira.

I honor the light in you.
Namaste.

Lindsay Martin
Written as M2 PCM Scholar



Homelessness

Better Days

I anxiously waited for our first meeting,
Should I be myself or resort to some formal greeting?
I was confident, brash, and perhaps too bold,
I walked in thinking it was you I was going to mold.
Little did I know that it would be your life story,
That would bring tears to my eyes with all of its glory.
Despite the windy road you treaded in your past,
Obstacle after obstacle you seemed to surpass.
Where on earth did you get that indomitable spirit and permanent smile?
You made it seem that the hardships and lessons were all worthwhile.
Cathedral Shelter empowered you to take control of your life,
Housing and support they provided to lessen the strife.
But there was still one area where an advocate you hoped to find,
It was your health that prevented you from having peace of mind.
Dressed in my white coat, that was my cue to step on stage,
The medical student to the rescue, your problems I would disengage.
But somewhere along the way, I lost grip of your hand,
The relationship we built cracked under the pressure of high demands.
There you stood having to face the challenges alone,
And day after day addressing your health just got postponed.
Finally after days of waiting you could wait no longer,
The pain was unbearable, only getting stronger.
And alas the medical student was nowhere to be found,
The problem with communication was just too profound.
I think back to that day with a deep sense of regret,
A lesson like this I know I can never forget.
This whole experience has humbled me like never before,
I realize there is so much between us that we need to restore.
I look forward to better days where our efforts are united,
And as we navigate the system, with our outcomes we'll be delighted.

Poonam Merai

Written as M2 PCM Scholar

Over the past several months, I worked with the Cathedral Shelter for the PCM homelessness track. As medical students, we have discussed many of the barriers that make it difficult for homeless persons to obtain health care. Most of these factors are quite obvious, including lack of insurance, transportation, and financial means to obtain health care. Furthermore, many homeless persons constantly relocate, which makes maintaining a primary care physician nearly impossible. Although several of these factors were obstacles while working with my patient, I think that one of the most difficult barriers was attempting to obtain the trust of my patient over such a short time period. It was this task that proved to be the true determinant of how successful I would be throughout these months.

The Cathedral Shelter offers a wide variety of services to its tenants and others in the community, and I hoped to be able to provide my patient with an avenue into the health care system that is often difficult to navigate. Since my patient has two children, I was eager to ensure that all of them obtained medical care; however, this required far more than just scheduling an appointment. Like many homeless persons, my patient has had a long history of ups and downs with a variety of community outreach programs. Because of this, my patient seemed wary of accepting my help, unsure of whether I could be a useful advocate. Although I admittedly failed at first, I eventually learned to be more consistent and work to convince my patient that health care is an important priority by maintaining frequent contact over the phone. Undoubtedly, an important facet of establishing such a relationship is maintaining frequent contact while showing an eagerness to be their health care advocate whenever they may require it. I would recommend that anyone in the homelessness track next year be proactive, consistent, and dedicated to identifying and meeting the needs of their patients.

Lauren Herman

Written as M2 PCM Scholar

This a set of *haiku* represent the difficulties in establishing healthcare as a new priority for homeless patients. Two come from the student perspective while the other two represent my patient’s point of view. Rather than referring to a season, as is traditional, I have used “communication” and the “clinic appointment” as the organizing words of each poem. The terseness of the haiku format limits the ability of the author to elaborate, instead forcing staccato structure. That terseness and constraint exactly captures my experience with my patient: our interaction has been short and direct but incomplete, leaving a vast expanse of the unexplained, unaddressed, un-understood. Indeed, the four haiku here lack a resolution—because that conclusion has not yet occurred in my relationship with my patient.

communication

homeless: no phone, no e-mail,
can’t leave a message

communication

cell phone, gchat, e-mail, texts—
visits take too long

clinic appointment

just a check-up, a screening;
feels forced, insincere

clinic appointment

no need, no emergency;
no money, no show

Alexandra Larson

Written as M2 PCM Scholar

New Beginners

When I decided to work with the homeless population for PCM I expected to be working with the people you see walking the street or peddling on street corners. I never realized that in addition to that there is a whole population of people that may not be on the streets, but do not have a home of their own they can go to. Some have friends or relatives to live with but cannot anymore because of the poor environments that came along with them. Some have had past legal, mental, or illicit drug abuse problems and want to really make a change this time around. Furthermore, I have seen how hard it is to truly change everything after the pasts some people have gone through. My patient has a past with mental illness, drugs, alcohol, and abuse which is not uncommon for the homeless population. She has had many ups and downs and back and forths. I felt at times I did not understand why people make their lives come to that. But, after getting to know my patient I realize she never asked for that life, she doesn't enjoy it, and she wasn't given a real fair chance to overcome these problems from the start. I also came to realize why it is hard to get patients of this population to come to their appointments and follow ups. It's easy for someone like me, with all I have been given, to actively take control of my health. But for someone who has experienced a lifetime of use and abuse as well as transient relationships, it is hard to trust people. Even though I feel like I am someone trying to help, she still may feel this is just one more person that will let her down once again. PCM has made me realize how important the patient-physician relationship is because after getting to know my patient as a person I realize that even though she has not exactly done the best at managing her health, I can see why it has been so hard with all the other serious problems she has had. If I was in her shoes/situation, it would have been easy for me to overlook my health as well. My eyes have really been opened to this group of people and I have started to see them not as a population of "homeless" but as a population of "new beginners".

Daniel Bunzol

Written as M2 PCM Scholar

A Hole in the System...

I have learned a good deal from participating in this program. I have learned that there is a large difference between the priorities of members of the homeless population and the priorities of a set of medical students. To us, medical care is part of life. It is a priority regardless of how healthy or unhealthy one might be feeling. Yet, for many of the patients we have worked with, this is far from the truth. When it is a struggle to ensure that you will have food to eat tomorrow, it is hard to see the value in well health care. If something does not feel wrong right now, there seems to be no need for doctors. This difference in values made it very difficult to establish the type of relationships we were hoping to establish. Even when I thought we had made some progress getting to know our patients and their connection with health care in the past, we were repeatedly disappointed as patients failed to come into clinic.

While it was hard to grasp, we missed the vital step in making this relationship truly successful. We assumed that if the patients became comfortable talking to the medical students, it would be enough to bring them into clinic. However, we needed to take a step back. We needed to explain and make sure that the patients truly understood why they should want to come into clinic and how important it would be to their future well-being. Without this vital step, the program cannot succeed in creating the in-clinic relationships it set out to create. Hopefully, this experience can help next years' group understand that the first step to a successful relationship is helping the patients to really want to obtain healthcare on their own. Without this drive, whatever effort we put in is going to be unanswered. If we can succeed in teaching the importance of healthcare, then hopefully we have altered the way that these patients will address healthcare now and in the future.

Elizabeth Sokol

Written as M2 PCM Scholar

A Little Perspective

Growing up in a “doctor-centered” household, I have to admit it came as quite a surprise to me that the doctor-patient relationship needed to be a topic of discussion. With two doctor parents and two aspiring doctor older siblings, medicine was a major talking point at most family meals during my childhood and the doctor-patient relationship was a given. When my dad drew pictures of hearts for us, it had valves and chambers, and when my mom took us to school, we’d better pick up the pace so she didn’t miss rounds. So I figured by the time I was old enough to understand the word relationship I thought I had a pretty good grasp on the doctor-patient relationship. It was easy: patients paged you with a problem in the middle of the night and you told them what to do (i.e. “well if you really can’t breathe, I think you should go to the ER” or “take two of these and call me in the morning.”) Of course I wasn’t an idealist. I knew patients didn’t always do what their doctors told them because when people at church were downing cookies by the dozen, they always said to me, “Shhh, don’t tell your dad.” So when I entered the “patient-centered” medicine program I really thought I knew what to expect.

However, things did not quite turn out as planned. I thought, from my vast experience of growing up with doctors, that I would just do what my patient asked me to do, go with her to the clinic and make sure she felt she could call me with any problems. I was excited to work with the homelessness concentration, and was especially interested in the Cathedral Shelter. It seemed like (and really is) a great program serving a needy population. I was also excited to meet my patient, hear her story and find out what I could do for her healthcare. What I didn’t expect was to have to see so much from my patient’s perspective. I had the class syllabus so I knew what was expected of me and it never occurred to me that I had to rely on the expectations of others to make my clinical experience work.

My patient was great; she was easy to talk to and had health concerns that were easy to deal with. But finding a time for three adults to meet at the clinic was not quite as great. I have to admit I felt pretty stretched to limit. First I’d have to email my preceptor to find times, wait for a response and then call to check with my patient, wait for a response from

her and then repeat it all over; all while making sure it fit in my schedule while keeping up with classes. So when we finally got a date to go to the clinic, it had been a couple of months since we met last, and my patient did not show up. I was shocked. I had called to confirm the appointment, had made sure she knew where it was and had done everything I thought I was supposed to. I never thought that she wouldn't come.

I talked over what had happened with my preceptor, the other PCM students, my friends, my parents, basically anyone I thought could shed some light on the situation. I came across the same sort of response each time; those are the obstacles when dealing with that patient population, or any patient population. That idea really made me reconsider the doctor-patient relationship, as I understood it. I had spent so many years getting the relationship from the doctor's point of view that I had completely forgotten about the patient's perspective. Patients don't get syllabi and they don't get ECM classes on the doctor-patient relationship, so how can they know how it is supposed to work? That has to be the best (but not the only) lesson I learned this year in PCM: to see through the patient's perspective a little. After this insight, I realized that if I wanted a relationship with my patient I would have to keep trying to make it happen. I would have use what I learned to be a model of the relationship for my patient, but also keep in mind what an individual patient needs and expects from that relationship. Just like pathology or CPP, what we learn in class about relating to patients is just a jumping off point. In order to do it right it has to be practiced, and this experience was a great way to do just that. I may have some more misconceptions to work on, but PCM gave me a new start and new perspective on what the doctor-patient relationship means.

Kelley A. Williams

Written as M2 PCM Scholar

Serving Diversity

In every population, there are certain common elements, certain shared traits that are more popular than others. The immense complexity of the human mind and human society lead to extremely diverse situations in every human population. I, like most people, struggle daily to categorize and uncategorize every person I see.

I joined Patient-centered Medicine last year in an effort to develop an elegant sense of what being a physician and being a patient meant. And I joined the Service Learning Program to develop an effective understanding of what serving a population meant. I joined both years to uncategorize the categories. Both times, I have found that the essential element of medicine is respect. Physicians must earn patients' respect, and patients must be treated with respect. Otherwise, the exam room is really nothing but a drug store drive-through. The knowledge of the physician falls on deaf ears. All the ability patients have to heal themselves (and there is enormous ability) goes undirected. Ultimately, my job as a physician is to answer two questions that every patient comes in with: "What do I have?" and "Why should I trust you?" I am improving in my ability to answer both of those questions every day, and that feels good.

My experience in serving the homeless population has been extraordinary, especially in its diversity. The paths that lead anyone to a 15-minute clinical interview are impossible to categorize. Homeless people get to be homeless by abandonment—either their support networks abandon them, or they abandon their support networks, or drugs, mental illness, society, and yes—bad luck, leaves a person without a home. But a person without a home still has his or her own unique (and it is always unique) story to tell about how they arrived at homelessness.

My greatest moment of learning this past year has been understanding that I am a servant of diversity. I don't judge people as being right or wrong. I don't have life lessons to share, wisdom on ethical dilemmas for my patients to learn from. I simply help the unique story of every person I see—I provide freedom from pain and impairment whenever possible. Each patient defines pain and impairment in his or her own unique way, so I think the onus really is on us, the future and current healthcare

providers of the US, to be a servant of that diversity. Our patients come to us as diverse stories, but we all too quickly seem to ignore those stories in favor of our own clinical dogma.

I don't fault physicians for screening out diversity in their jobs. They have 8.5–15 minutes with every patient. Every physician has a simple goal: figure out what the patient has, and do what you can to fix the problem. Being scientifically trained, we work to categorize symptoms and life circumstances into a diagnosis. Scientifically we are trained in what is "the" norm, and how to find "the" problem, and what "the solution" for each problem is. There are a lot of different diseases and problems in medicine, so we have to use the Aristotelian system of categorizing things to keep medical knowledge organized in our minds, ready for the bedside. We have to use reductionism to figure out what the smallest pieces of any medical problem are, and then build the most complete picture of disease possible out of those pieces.

The problem with scientific understandings of disease is one of context. The idea of disease comes wrapped in the diversity of the life experience of the patient who has the disease. I will practice openness. Because I know, that if I don't take a little time with each patient we see to appreciate their unique story, I have no basis on which to treat them. The patient and I must see any disease, any problem in the same light. Once I've done that, I'll move on to dispensing drugs and clinical advice. But not before I make space for diversity.

Ben Goold

Written as M2 PCM Scholar



We've all engaged in some debate about health care access given the current political climate. Not having insurance is a barrier to health and being unemployed is also a barrier to health care access. Imagine being homeless on top of that? Health care might not even be a priority when your basic needs aren't being met. Surely, eating and safety come before seeking access to health care. Unstable housing situations or a relatively nomadic lifestyle make it difficult for people to commit to healthcare and have consistent access. It might be easy to wait in line at Cook County in order to take care of immediate concerns like a wound, but taking medication for hypertension is opening up a whole 'nother can of worms. Medication adherence entails being able to afford medication, pick it up, and keep it safe. That isn't necessarily a top priority for homeless patients. And for some, it isn't even a possibility. Creating a sustainable health care system that works for people WITH homes has been an uphill battle in this country. Creating a system that works for homeless people is even more trying.

We have found that the individuals we interacted with at Cathedral Shelter usually came from families with substance abuse issues or suffered some degree of trauma—whether it was war, the death of a loved one, or incarceration. This knowledge led to our appreciation of the systemic and cyclical nature of homelessness. An unstable childhood often begets an unstable adulthood. The concept of a “level playing field” was shattered by our interactions with the residents at Cathedral Shelter. And our concept of homelessness was simplified. A homeless person is someone without a home—not a lazy person, or an uneducated person, or someone that lacks insight. There is no “stereotypical” homeless person. We don't get to choose the families we are born into, or the values they demonstrate for us. Instead, we use those things to navigate the world, however steadily or unsteadily. If anything, our experiences at Cathedral Shelter have unified the common human experience and reminded us that at the core we have far more similarities than differences, despite our fortunes or lack thereof.

Taking Flight

Suffering has
No gender
Has no definite
Shape

Lies on thresholds
Sleeps on streets
Couches
Park benches
And temporary beds
Lacks comfort
Trust
Space

Only circles
Of past
Encroaching on present
Childhoods
Where liquor flowed freely
Relationships that started sweetly
With heroin kisses
Ending with heroin and love withdrawal

Suffering has a degree
Has a home
Had a home
In and out of homes
Had a stable relationship
With a substance
With abuse
With loneliness
With loss
Guilt
Famine
Feast
Love lost
Love left
Love never given

Behind jail bars
Lies jailbirds
Singing out
For glory
For a better way



Wanting to be treated
With humanity
Respect

Because no matter
The circumstance
Those that have
The fight or the fuel
To dream their way
Out of limited
Existence
Know that respect
Is a right
Not a privilege

Suffering
Cycles on
Has a beginning
And for some,
Has an end

Sing with us
A song for the
Jailbird
For the sage
For the frightened child
Turned adult
Shaped by life's circumstances
But not defined by them

It is not our boundaries
That shape us
But when we take flight
And how we escape

Jade Pagkas-Bather
Written as M2 PCM Scholar

Homeless—a person without a home.

i don't like it when a person is defined by what they lack—whether it's a home, a job, citizenship, or health insurance.

people have so many things to share. the homeless may not have a bed for me to sleep in but they have stories and wisdom. i remember our first visit to the cathedral shelter. we sat in a large room, our timid group of medical students on one side of a large table. a group of residents, recovering from substance abuse and without their own homes, seated on the other side.

on one side of the table was a lot of education—facts, statistics, and complex concepts. on the other side was deep wisdom—hard lessons learned from hard lives. who do you think were the teachers in that session?

at that first session, i recognized that the residents of the cathedral shelter had two things in abundance that are so rare to find in Chicago. first, they had a supportive community. they had a roomful of friends that they cared for another. they would shake their head in empathy and offer words of encouragement when the person sitting next to them would share painful moments from their lives. they held one another in the highest regard. they shared a strong and undeniable bond that has been essential to separating them from their drug habits. second, the residents were filled with insight. when talking about challenges in their lives, they didn't blame others or call themselves weak. they blamed low self-esteem, a lack of healthy outlets to blow off stress; they blamed depression and apathy. they knew better than anyone else what had happened to them and what was needed to get things straight.

the first session also left me with the question—who are the homeless? are they a homogenous group with similar stories? at cathedral shelter, they all share pasts of substance abuse that have led them to homelessness, but in terms of the environments they grew up in or the lives they've led before they got to the shelter, it's just as diverse as our own student group's history.

some residents have college degrees. most held full-time jobs and supported families while using drugs. one resident grew up in a wealthy northshore suburb. the stereotypes of the homeless as lazy, uneducated, and completely alone were often far from the truth. again, we see the fallacy of defining people by what they lack—lumping them in one big category, as if they all came from same foreign place.

but we want this fallacy. we want to believe that that homeless man on the corner asking for money is fundamentally different from me. it helps us avoid uncomfortable feelings. it also helps to further marginalize people those that are homeless, pushing them farther away from society and help, and in to the arms of bad habits. if there are any themes of the stories of the residents at cathedral shelter, it's rejection—rejection from their own family and from our society, but worst, a certain learned rejection of themselves.

but really, i know very little.

i've gained a lot as a participant of the PCM program. i've developed strong relationships with my classmates who i worked with over many months. my stereotypes towards the homeless and other marginalized groups have been challenged. i was confronted with the complexity of the health care system and the difficulty of navigating it from the perspective of an outsider—a patient. i learned to stop and listen to the stories of my patients, they have a lot of insight to share. i'm happy with the the PCM community as a whole, i found it extremely supportive of me as a person and my beliefs and philosophies. it's been positive reinforcement from the examples of our preceptors that one can be a good doctor and a good human being.

that's it.

Daniel Yang
Written as M2 PCM Scholar

Communitylessness

I saw your tattered clothes,
but didn't see your eyes

I listened to your pleading,
but didn't hear your voice

I knew you held a cardboard signboard,
but did not know what was written

And because you made a profession of asking,
A little change and paper would only make us weaker

A fish only lasts for a day.

I lock the locks and raise the radio,
Hoping the tunes will keep you out

Driving past I felt heavy,
But I didn't feel your thoughts

You were less a home and I was less help.

But now we sit face to face,
With no windshields intervening

A stethoscope on my shoulders,
but I refuse now to let it get in the way

You tell of your journey,
and I share mine
As that's what friends do.

We grew up in the same zip code,
but were raised in different worlds

You come from a plague of cracked belief
and beer-goggled perception

I come from milk and Cheerios

And as our thoughts mix and mingle,
and ideas go back and forth,

We find each other holds the latchkey,
to set the other a little more free

We each gain new understanding,
which is prerequisite to healing
And as you get to leaving
We tell each other with a smile,
It was a good and fruitful meeting.

I want to look you in the eyes now
I want to hear your voice

I put it in reverse.

Neither of us knew that as you reached out
It was an offer to save us both

To your outstretched arms seeking alms
I fill you palms with my hands

We stand together at the intersection,
With cardboard emblems rewritten,
When lights turn red we walk out amongst the metal

Our new signs held high:

We are Hungry.
Will work for Community.

Greg Schweitz
Written as M2 PCM Scholar



immigrant
&
Refugee Health

A New Life

A whole new life of possibilities.
My heart and mind remain strong,
to prevail against all probabilities.
Now it's time to right all wrong.

A whole new life of health,
lacking needless pain and suffering,
the world's true wealth.
Spite and exile replaced by caring.

A whole new life of hope,
for my children and baby coming.
Challenges we gladly cope,
knowing what our future's bringing.

Lucy Vine

Written as M2 PCM Scholar



I love to travel, and before I started medical school, I took advantage of every opportunity I had to visit a new place. The new sights, experiences, and perspectives were exciting and enlightening, and I often felt that my life was enriched by those new places and what I found there.

Even though I still enjoy traveling, since starting school I haven't been able to do nearly as much of it, and I definitely haven't been able to have the sort of month-long immersive experiences I enjoyed before. So while I enjoyed my time in PCM learning about the experience of a refugee here in the United States and I expect that what I learned will inform my interactions with patients in the future, what I've enjoyed the most about getting to know my refugee patient is the things he's taught me about Burmese culture.

I've learned about Sepak takraw, an immensely popular sport that resembles a cross between soccer and volleyball. I've learned about the life and struggles of Aung San Suu Kyi, the Burmese Nobel Peace Prize winner and political prisoner of the current regime. And I've learned about the cultural and political climate and even a tiny bit of the language of Burma.

It certainly hasn't been the same as traveling there, but the cultural exchange I've been privileged to share with my patient has been very rewarding, and in some ways just as enlightening as if I'd visited there.

Jeremy Howe

Written as M2 PCM Scholar

Anonymous

When I missed her call on Thanksgiving, I couldn't believe it. Of all the times and of all the people, hers was the call I could not get to on that day. So I ended up missing the birth of S.H., E.P. and H.W.'s first daughter born in the United States. When we spoke hours later, S. was safe and sleeping with mom and dad. And when E. asked me to explain to her husband's boss that he would need a few days off (he doesn't speak much English), I said that I would be glad to do it.

I met E. for the first time two months prior at the Heartland Alliance Office after the liason between UIC and Heartland arranged a meeting for us. When we sat down together I knew right away that she was a good person. There was a certain presence she had when she entered the room such that speaking with her in broken English was new yet not uncomfortable. After several "please"s, "thank you"s, and other pleasantries we departed each others' company. Who we were to each other was foggy at best, she was a refugee from Burma and I was a second year medical student. How did we meet in such a way?

I began the Patient-centered Medicine Scholars Program in the Fall of 2007 in one its first years in existence. The idea of the program is almost self explanatory: to practice medicine that puts the patient as the center of care. It seems like a nice idea, and in fact it is a nice idea, but the functionality of it is a different story all together. Being in medical school is about learning a lot, it's about people expecting a lot, it's about feeling like you should and possibly could do something about it, but the chains of the short coat are light years from being removed.

There is a certain shakiness to medical school. It is like your capability is in a constant state of limbo: you can do this, you cannot do that, you would get in trouble if you said that, and if you

see someone else either doing that or NOT doing that, say something to your superior, and if that someone is your superior in the first place then...well I still don't have that part sorted out in my head yet. It's all very confusing. Add to the mix the idea that you are supposed to hold a patient's hand (a real patient and not a perfectly scripted simulated patient in a controlled environment) throughout the course of their care is simply mindboggling.

After I left the first meeting with E., I was overcome with a sense of tranquility at having been in the same room with her. But shortly after meeting her I was struck with a sense of incompetence at possibly depending on her for more than she could expect to gain from knowing me.

At this point there are not a whole lot of medical questions I can answer for her. I attend clinic visits with her though and we talk about some of the pamphlets she has received from the clinic because the English does not always come that easy for her. But she came to me when she needed to get her son, E.T.L. into preschool and I brought the paperwork into the school. And mostly when we talk, it is not about medical matters; there are family concerns, stories about home, tax and bank confusion.

So in the end, Patient-centered Medicine makes a lot of sense to me because it is about two people getting along. I get a little choked up when I think about E.T.L. leaving for school on his first day of preschool in the fall later this year. My heart is better because of the missed call even. Because while I didn't make it to the first day S. was born, the fact that E. called at all leads me to believe my presence is worth something to her and her family.

Bianca Castellanos

Written as M2 PCM Scholar

Helping People

One of the many reasons I wanted to become a doctor was to help people. Although this reason is often looked upon as vague, idealistic or simple-minded, I am coming to realize that it is just the opposite. Helping people as a physician is noble, complex and necessary, and, more importantly, learning exactly how to help people is an invaluable skill that, as medical students, we should be trying to soak up as much as possible. Working with Nadia, an Iraqi refugee, has been an irreplaceable experience in beginning to develop some “helping people” skills. Nadia and her two pre-teen children were resettled to Chicago about three months ago. Since then, they have had multiple doctors’ appointments to assure that they are in good health and have all their necessary vaccinations. On one of these routine visits, Nadia learned that her son had Hepatitis B. She was terrified. She could barely eat or sleep. We spoke over the phone several times and I felt horrible. I felt like there was nothing I could do to help her. As a student, there was limited clinical advice to offer, and as a younger adult, I felt slightly inexperienced to offer serious emotional support to this woman who had been through so much in her life already. I was, however, able to attend the follow-up appointment with her. Part of me was relieved to be able to do something, but the other part of me was scared for Nadia and her family and, again, how I would be able to be of any help. The time leading up to the appointment was very tense, but the news the doctor gave was actually better than expected. Nadia is a very empowered woman and she asked all the questions and received all of the information that she needed during the visit on her own. I barely did anything. But when we said goodbye that day, Nadia gave me one of the biggest hugs I’ve ever received, looked directly at me and said “thank you.” She could have done it on her own, but she didn’t want to. She wanted to have someone on her side and I was lucky enough to have the opportunity to be that person. I learned that helping someone is not always a tangible action. Rather, being there to support someone, regardless of whether you have all the answers or skills, can be so much more meaningful and powerful in building relationships with patients. Although it wasn’t how I had originally expected, I truly feel like I was able to help my patient and her family.

Lisa Pearl

Written as M2 PCM Scholar

Barriers: Walled in with Nowhere to Turn

As he started his car and slowly drove down his driveway one sunny morning, Mr. A. anticipated a day at the office just like any other. While exiting his driveway, an unidentified vehicle came roaring down the street and purposely slammed into the side of Mr. A.'s car. Next, a man stepped out of the offending vehicle and fired several bullets at Mr. A. Four of them struck Mr. A. in the arm. There was no clear reason for why this attack occurred. The attacker remains unidentified even today, one year later. However, one thing is clear—this series of events have changed the life of Mr. A. and his family forever.

Mr. A. once lived a perfect life. Okay, perhaps the fact that foreign nations had entered and upheaved his birthplace and residence for the past 50 years, Iraq, threatened the notion of an ideal environment for a perfect life. However, compared to most Iraqi civilians, Mr. A. and his family were “very content” people.

Throughout his life, Mr. A. worked very hard and diligently so that he could one day enjoy the fruits of his labor with his family. He was a high ranking civil engineer in the Iraqi government while his wife taught electrical engineering at the city university. His two oldest children were grown up and married. The middle child attends pharmacy school in Egypt. Meanwhile, the two youngest are just 6 and 11 years old. He had a very nice home and a large circle of family and friends. Baghdad, Iraq was Mr. A.'s home.

Following the assassination attempt in Iraq, Mr. A. was taken to Jordan for urgent medical care, and then brought to the United States as a refugee. He has come with his wife and only the two youngest children. Unfortunately, Mr. A. and his family feel devastated to leave behind their homeland. They have lost their home, money, property, and sentimental belongings. They have lost touch with their two children and their families in Iraq in addition to

their vast circle of close friends and relatives. Everything that Mr. A. and his wife worked for their entire lives is now gone. They are now in Chicago with nothing. Their engineering degrees hold no value in the United States either. Mr. A. and his family feel trapped, with nowhere to turn.

Fortunately, since his arrival in September of 2008, I have been fortunate enough to become an integral part of Mr. A. and his family's health care. My experiences with Mr. A. have taught how to serve as an advocate for a patient and also how to navigate the U.S. health care system with limited resources. Mr. A. is currently obtaining regular therapy for his arm injury. In addition, he has been suffering from serious post-traumatic stress syndrome since his initial attack one year ago that interferes with his ability to concentrate and sleep. Starting in April, he also will be getting therapy to help him overcome post-traumatic stress symptoms.

Leaving behind one's most cherished elements at the complete opposite spectrum of the globe and being forced to start afresh in a new land is no easy task. Therefore, the Immigrant Health portion of the Service Learning Program is doing a great service by teaching medical students such as myself about how to advocate for a population in desperate need in order to better their lives in the United States of America.

Rohan Shah

Written as M2 PCM Scholar

*I met a patient—
Not only an immigrant,
but also a friend.*



Samreen Choudhry
Written as M2 PCM Scholar

Aylin O.

First meeting:

I had not spoken to Aylin before I met with her. L., my student-partner in SLP, had already spoken and met with Aylin before. I was not sure what to expect. Would I be able to understand her and would she be able to understand me. How would our first meeting be? L. and I waited for Aylin's English class to end. We could hear the teacher in one of the other English classes discuss all the items in the bathroom with her students: toothpaste, mouthwash, towel, bathmat... Soon the waiting area was filled with people as English classes ended. L. stood up and went to meet someone. I couldn't see the person she was going towards; I followed her. She was hugging a kind looking older woman (who I could only assume was Aylin) and then as is the greeting custom in many countries they kissed on the cheek three times. I introduced myself after we had walked into a quieter room and shook hands with Aylin.

L. had told me a little about Aylin. She was from Iraq and had to leave the country due to threats. I had also heard from her that Aylin liked to crochet, but that was all. During the next hour, I learned about Aylin: her life in Iraq, her family, her students, why she had to leave, and where she was before coming to Chicago. I also found out about her health: she suffered from some knee pain and her son who was living with her was diagnosed with PTSD. I was surprised at how easy it was to communicate with her (I discovered later that she was both a student and a translator for different English classes). When we had some difficulty understanding each other, we used hand-gestures and drawings to communicate.

She was friendly, enthusiastic and willing to explain anything I was unclear about. She was involved in many of her church activities and came to classes at Heartland Alliance often. Her positive

attitude and energy made me realize how strong the human spirit is. At the end of our meeting Aylin and L. parted in the same manner they had greeted each other. At first, I was unsure what to do, but after Aylin came up to me and gave me a hug I knew. We had met as strangers but were parting as friends.

Following up with Aylin and attending a clinic visit:

I called Aylin and spoke with her several times before attending a clinic visit with her. Our conversations on the phone were general but we became familiar enough to recognize each other's voices. Every time I called there was a chorus of thank-yous from her as we were about the end our conversation. I thanked her back because I felt fortunate to have met her and learn from her.

At our first meeting Aylin had told me about Dr. A., the doctor she and her son were seeing. She said "He is a very good doctor" and she was happy with the medical care she was receiving. At the clinic visit, I found out one of the reasons why Aylin and Dr. A. had such a good relationship—they both spoke the same language and shared a cultural heritage. Dr. A. was from the Middle East and spoke Armenian and Arabic. Aylin, her son and Dr. A. spoke in Arabic during most of the interview. Though, I couldn't understand the language they were speaking, I did understand how comfortable, open, and affable their relationship was. During the clinic visit with Aylin, I realized how important cultural sensitivity and language is to the patient-physician relationship.

Mechu Narayanan

Written as M2 PCM Scholar

Reflections on Refugee Healthcare

“Kul, not C-O-O-L”

His name is Kul, Not C-O-O-L

It was not cool, when they said he must wear their traditional dress and not his own.

It was not cool, when they said he must have Buddhist monks for their marriages and ceremonies, and not his own.

It was not cool, when they said the Nepali language was not to be recognized.

And burned their language book in the streets, banned it from schools, and their culture became ostracized.

It was not cool, when they tortured his father’s arm for speaking a voice of freedom, shouting for human dignity.

A price they and we paid for the monarch’s inhumane insanity.

It was not cool, when they stripped him, his family, and a hundred thousand other eastern Bhutanese citizens,

Of their home and life in Bhutan who were eastern Bhutanese citizens.

It was not cool, when his home became a refugee camp in Nepal, Where he faced 18 years trapped inside with not much at all.

As they became unwanted members of the world, not a real Nepali, no more a Bhutanese.

The conflict had left him and hundred thousand others, looking to the world to lend a hand, please?

His name is Kul. And it was not C-O-O-L

“Too cool”

Coming to America, came with a new challenging situation,
A new place without familiar sights, sounds, or community, and in
addition,
Healthcare access became a dire need for his chronic back pain
condition.
8 months of refugee medical assistance,
Not enough for real health sustenance.
But too cool Kul kept smiling,
Believing a solution was in the silver lining.
So we became partners in crime,
I became his patient advocate, in due time.
So he searched for a job, limited by the pain from his back.
But too cool Kul was always on the attack.
A victory came as a hotel job at the end of December,
Able to support his family in the midst of daily pain: a day to truly
remember.
To local hindu temple our families both went,
To express their religious freedom once again, a great deal it
meant.
Yet the pain has not stopped
From all those pain-killer pills he has popped
He now waits for hope: A spinal cord stimulator.
But too cool Kul and I, have not backed down from perils of failure.
He taught me again that strife,
Is just part of the fight.
A mere battle in this game of life.
Because if we did not know what struggle looked like,
We would not know victory and its glorious might.
Too cool Kul, was pretty cool.

Amish Desai

Written as M2 PCM Scholar

2007–2008 M1 STUDENTS

Bhavna Balaney	Ryan Jacobson	Bhavisha Patel
Katie Bochenska	Geena Jester	Lisa Pearl
Daniel Bunzol	Yuna Kang	Priyanka Rajaram
Bianca Castellanos	Adrianna Kashuba	Motasem Refaat
June Chae	Azhar Kothawala	Bethany Schmidt
James Cheon	Michael Kurzer	Rohan Shah
Krista Childress	Jeffrey Larson	Elizabeth Sokol
Samreen Choudhry	Ken Lau	Ashley Styczynski
Nathaniel Copeland	Eunice Lee	Lauren Taglia
Blake Fleeman	Jennifer Lo	Stephanie Toth
Clara Fuentes	George Manatt	Raphael Vega
Kevin Go	Mary Mattern	Elizabeth Ward
Lauren Herman	Poonam Merai	Kelley Williams
Sophie Hermann	Laura Niiro	Anne Wu
Erin Horan	Caroline Novak	Miao Yu
Jeremy Howe	Christopher Ochoa	

M2 STUDENTS

Melina Beaton	Ariel Leifer	Jennifer Stromberg
Jennifer Boklewski	Brian Luc	Shea Suskin
Anita Bordoloi	Jing Luo	Renee Westley
Sae-Rom Chae	Carrie Nieman	Emily C. White
Vikas Desai	Chloe Kim Parker	
Christina Gamboa	Michael Richards	

2008–2009 M1 STUDENTS

Reema Arora
Gurvinder Bhardwaj
Ryan Carr
Olga S. Cherepanova
Amish Desai
Dan Goldstein
Ben Goold
Amanda (Mindy)
Guzman
Janie Hernandez
Adrianna Herrera

Olga Kantor
Anubhav Kapoor
Lauren Kendall
Candice Kim
Walter Kim
Adam Kney
David Kosoff
Tal Levin
Denise Lopez
Domowicz

Kathleen Elizabeth
Mandell
Lindsay Martin
Jade Pagkas-Bather
Nichit Shah
Brian Sindelar
Lianne Torres
Peter Ureste
Yulieth Vento
Lucy Vine

M2 STUDENTS

Jamie Brewer
Daniel R. Bunzol
Bianca Castellanos
James Cheon
Krista Childress
Samreen Choudhry
Nate Copeland
Blake Fleeman
Lauren Herman

Jeremy Howe
Geena Jester
Michael Kurzer
Alexandra Larson
Jeffrey Larson
Ji Yeon Lee
Jennifer Y. Lo
Poonam Merai
Laura Niiro

Lisa Pearl
Bethany T. Schmidt
Rohan Shah
Elizabeth Sokol
Ashley Styczynski
Lauren N. Taglia
Stephanie Toth
Kelley Williams



2009–2010 M1 STUDENTS

Ivana Brajkovic
Benjamin Carney
Meenadachi
Chelvakumar
Celeste Cruz
Janet Cruz
Angel Desai
Badewa Fatunde
Luis Grau
Rachel Guild
Maria Elisa

Hernandez
Dempsey Hughes
Anne Jennings
Richard Keyme
Tiffany Kim
Kajorn
Kitiphongspattana
Samantha Knox
Elizabeth Messer
Mara Motley
Yury Parra

Gregory Podolej
Melissa Preyss
Rashell Reynoso
Nathan Stackhouse
Corey Thompson
Laurine Tiema
Julie Tsay
Sumant Tumuluru
Yesenia Valdez
Shari Vasquez

M2 STUDENTS

Maria Angulo
Olusola Balogun
Olga Cherepanova
Amish Desai
Dan Goldstein
Ben Goold
Amanda Guzman
Anubhav Kapoor

Lauren Kendall
Adam Kney
Tal Levin-Decanini
Kathleen Mandell
Lindsay Martin
Mechu Narayanan
Emily Newman
Irida Nikolla

Margarita Nisman
Jade Pagkas-Bather
Gregory Schweitz
Nichit Shah
Lianne Torres
Peter Ureste
Lucy Vine
DanielYang

