Spring 2023

The Perspective

A quarterly newsletter published by the National Med-Peds Residents' Association in collaboration with the Med-Peds Program Directors Association & the AAP Section on Med-Peds

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Dear Med Peds Family,

This year as President has flown by. It has been an absolute blessing to watch as our board has gone above and beyond to recruit a diverse incoming Med Peds intern class and to serve the Med Peds community as a whole through all of the various programming they have put together. I look forward to everything our next board will accomplish with Dr. Stephanie Lee at the helm.

To all of our graduating residents, wherever they may be headed next, first I would like to take the time to thank you. Thank you for how you served your communities during your intern year as the world learned of COVID-19. Thank you for your mentorship to so many other residents and medical students, including myself. This class will always share a special camaraderie that few can comprehend from being on the frontlines in the early days of COVID-19. We look forward to all you will accomplish in your careers as Med Peds physicians.

To our newly matched fourth year medical students and soon to be interns, we cannot wait to meet you. Over the next four years, I hope that you are as reaffirmed in your decision to pursue a career in Med Peds as I have been. I hope that you feel like family here and that NMPRA can serve as a home to you. Please do not hesitate to reach out to any of our board members as you navigate your professional identity formation. We are here to serve you as you advance through residency and on to your careers.

Thank you again to the entire Med Peds community for entrusting me with the role of leading NMPRA this last year. It has truly been the greatest honor and privilege of my time in residency.

Joyfully,

Maria Siow, MD
NMPRA President 2022-2023
President@medpeds.org
Please fill out the Med-Peds Workforce survey. The Med-Peds community needs your help.

The AAP Section on Med-Peds (SOMP) still needs every Med-Peds physician to complete the Med-Peds workforce survey. If you have not already completed the survey, the link to the survey is https://www.surveymonkey.com/r/Med-Peds2022 or email Jackie Burke at jburke@aap.org.

We need every Med-Peds doctor (regardless of your memberships) to fill out the survey; even if you are in training, subspecialized, retired, or no longer involved in Med-Peds.

The results of the survey are vitally important to everyone.
-- It has been 10 years since the last Med-Peds Workforce was done; a lot has happened in 10 years!
-- It will show payers the various roles of Med-Peds in the care of children and adults.
-- It will increase interest in pursuing Med-Peds and highlight available opportunities.
-- It will assist with legislative issues when a framework of the Med-Peds community is requested.

PLEASE fill out the survey! Check your junk email! Help Med-Peds! We'll be drawing FIVE people for $100 Amazon gift cards!

Note that your responses to this survey are completely confidential. No identifying information will be associated with your responses and responses will be reported only in the aggregate.
A few of you may receive duplicates of this e-mail since we have more than one e-mail address for you. If that occurs, please respond to one of the e-mails with the word 'duplicate' and answer the survey from your primary e-mail account.

If you have questions about the survey or need help, please contact Holly Ruch-Ross at hruchross@gmail.com or Jackie Burke at jburke@aap.org

And now some other Med-Peds news.

Happy graduation to all the Med-Peds residents around the country. What a growing force we have in primary care, subspecialties, hospital medicine, and academia! Remember to stay involved with Med-Peds; if you keep your membership with the AAP (which is discounted for new graduates), you can join the Section on Med-Peds for free.

ACP 2023 was in sunny San Diego this year. The Section on Med-Peds Session hosted an educational session on "Attention Deficit-Hyperactivity Disorder (ADHD) and
Management" with Nabil Abou Baker, MD, Assistant Professor of Internal Medicine and Pediatrics at the University of Chicago. With the shortage of psychiatrists and the continual medical need for treating young adults with ADHD, this topic was well received and well attended! The session was followed by the Med-Peds reception.

Next conference will be the AAP National Conference October 20-24, 2023, in Washington DC. This looks to be something truly different exciting as we collaborate with the Section on Simulation and Innovative Learning Methods! The program, "The Medical Educator’s Digital Toolbox," will focus on practical, hands-on introduction to commonly used educational technologies. The program is scheduled for Sunday, October 22 from 9 AM - 4:30 PM. We will also be having our poster session and joint lunch with SOSILM (funded by NMPRA and Laerdal). Registration opens May 2 at www.aapexperience.org.

While at the conference, we also have an opportunity for you to have one-on-one discussions with Med-Peds attendees about personal health and well-being at the Med-Peds Wellness Booth this year. Please reach out to Jackie Burke (jburke@aap.org) if you are interested and want to volunteer. It is a great way to have conversations about personal well-being and to pass along the information we have at the Med-Peds Wellness Booth.

To continue to promote wellness, the SOMP is publishing a series of physician wellness articles in AAP news. See the April article at https://publications.aap.org/aapnews/news/1346?autologincheck=redirected.

What are you doing for your well-being? If you have not already done so, the Preventative Care Checklist can be found on the Section’s Collaboration page at https://collaborate.aap.org/medpeds/Pages/default.aspx under SOMP documents (AAP log in required).

Thank you NMPRA for supporting EDI through your advocacy series, mentorship program, and collaborations with SNMA and LMSA. The Section on Med-Peds is happy to help with the planning for a presence at next year’s SNMA conference.

Finally, are you looking for a place to publish scholarly activity? Consider a submission to Cureus and the Med-Peds Academic Channel (www.Cureus.com). The submission process is free if you submit to the channel!

Hope to see you soon! As always, if you have any topics that you would like the SOMP to address, please feel free to reach out.

Jayne

Jayne Barr MD MPH FAAP FACP FHM
Chair, AAP Section on Med-Peds
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Cureus is an Open Access Medical Journal dedicated to eliminating barriers related to writing or accessing medical literature. It’s a way for physicians, trainees, and researchers of all backgrounds to showcase their work and disseminate medical knowledge without having to worry about paywalls or copyright issues. It allows for fast publication without the red tape that is accessible to everyone. Best of all, Cureus is now a part of Springer Journal!

We have a dedicated Med Peds Academic Channel that is geared toward promoting scientific knowledge in our specialty in a fast and easily accessible manner.

Here is a link to our Cureus website in case you’re curious and want to submit something of your own:
https://www.cureus.com/channels/med-peds

Looking forward to seeing your submissions!

SUBMIT YOUR WORK TO CUREUS!

Email mpac@medpeds.org for any questions!
Dear Med-Peds residents,

On behalf of NMPRA, we’re hoping you can join us for the upcoming webinar

"Navigating a Combined Med-Peds Infectious Diseases Fellowship"

An Evening Session Aimed at Med-Peds Residents Interested in Combined Med-Peds ID Fellowship Training

During this webinar, we will provide insight and discuss best strategies for those residents considering and applying for combined Adult and Pediatric Infectious ID Fellowships. It will also include an in-depth discussion on the nuances of the application process, how combined fellowships are structured, and what career opportunities are available after training.

This webinar will include a panel of combined Med-Peds ID faculty and fellows from all over the nation to help answer questions and facilitate the process.

Please note that this is an informational session aimed at answering your questions and is not a job fair.

Join us virtually on:

**June 6, 2023 @ 8 PM EST**

If you would like to attend, please register using the QR code below. Please ensure that you register with the same email you use to login to Zoom.
One last hurrah from our Board

As the current board wraps up their term, we thought hear some of their perspectives on things outside the hospital!

Maria
Favorite show: Survivor

Stephanie
Hobbies: crocheting and playing any game in the Pokemon franchise

Dream vacation: Cycling through the Swiss alps

John

Bucket list: Rim to rim at the Grand Canyon

Favorite book: triology called the Broken Earth by NK Jemisin

Nicole

Juhi
Favorite movie: Yeh Jawaani Hai Deewani (an amazing Bollywood movie)
Valerie Figueroa is a MS2 at Universidad Autonoma de Guadalajara School of Medicine. She has been interested in Med-Peds since starting medical school in 2021. She became part of NMPRA during her first year of medical school. After attending the AAP and the Med-Peds conference in 2022, she partnered with her school’s local pediatric and internal medicine chapters to bring awareness about Med-Peds. She used the presentations provided at NMPRA combined with what she learned during the Med-Peds conference and presented a webinar for current UAG SoM students to learn about Med-Peds. She also invited a current Med-Peds resident and a Med-Peds attending to come to the webinar and provide their perspective on the fantastic world of Med-Peds. Historically, students from her school have yet to be accepted into a Med-Peds program, mainly because they do not know of their existence. She plans to continue bringing awareness of this fantastic specialty to current and future medical students at UAG SoM. She wants to encourage other students to join her in attending this year’s Med-Peds convention and get more medical students excited to apply to Med-Peds. She will apply to Med-Peds residency for the 2025 Match and hopes to be among the many students accepted from UAG SoM.
University of Arizona College of Medicine: Expanding the Chief Role

The University of Arizona College of Medicine - Phoenix Med-Peds Program is thrilled to share the creation of two new chief resident positions for the upcoming 2023-2024 academic year. These will be in addition to the two traditional chief roles (filled by Dr. Bethany Eiseler and Dr. Carson Morley).

Dr. Andrea Morley will be serving as the Chief Resident of Academic Affairs. She created this position to foster a community that celebrates curiosity and to formally serve as a resource for her peers as they navigate continued education and scholarly activity in residency. Andrea will be taking over as the head of the Clinical Reasoning Curriculum (see Spotlight section of the Fall 2022 NMPRA Perspective for more information on this resident-led innovation!), and she is eager to support her co-residents by connecting them with research opportunities, career specific mentors, and cultivating successful conference submission/attendance.

Dr. Miriam Robin will be serving as Chief Resident of Diversity, Equity, and Inclusion. In this position, she will build an anti-racism curriculum that investigates bias in medicine and empowers trainees and faculty with the clinical acumen needed to challenge inequity. Other goals include expanding underrepresented in medicine (URM) pipeline and recruitment efforts in order to attract, retain, and promote diverse trainees. Our program aims to integrate resources between different hospital systems in order to more broadly improve DEI initiatives on a GME, community, and national level.

The University of Arizona College of Medicine - Phoenix Med-Peds Program encourages other Med-Peds programs to consider additional in-training chief resident roles. These innovative positions encourage both personal and professional advancement in residency, and formally acknowledge the amazing work Med-Peds residents already do behind the scenes!
Essays

A 20 minute window

Kapila Patel
MS3, University of California, Irvine, School of Medicine

"You have 20 minutes, then come back and present"
Because clinic is busy today
And she is a walk in.

I open the door and what awaits me but
Wide eyes and a tip tapping foot.
Anxiety permeates the air.
I stop short.

A young girl in between
No longer a child.
Not yet an adult.
Frightened of the unknown.

I start with what brings comfort.
"How were your holidays?" I ask
A flash of surprise crosses her face
A small smile forming.

As we talk about tamales and pozole
Family visiting from out of town
Her shoulders once at her ears
Begin to drop inch by inch

Now more at ease
I ask her what brings her in today
And it was then that we began the visit
She was worried about a possible pregnancy

Fingers flying as she counts the days
Recollection of the heat of a moment
With no time for protection
Worry began to reform on her face

This 20 minute window
Another line in todays schedule
But for her a difference
Of two timelines

A pregnancy test done in clinic
Seconds ticking as the countdown continued
Palpable relief as it was in fact Negative.

The focus in medical school is to build knowledge.
But equally important is the nonverbal, nonfactual
I never know what emotional state Awaits me when I open that door.

A conversation was had to discuss the future.
Follow up visits were planned.
She held on to the hand that I offered.
A new trust forged between us.
Grecia Quiroga
MS3, MD/MPH Candidate, University of Michigan Medical School

"Hispanic community makes up more than half of coronavirus cases in Southwest Michigan county" was the headline on the newspaper that caught my eye in August 2020 – that infamous year that the nation went into lockdown to prevent the spread of what was still a new and emerging virus. It shocked me to realize that only three counties west of my south-central Michigan home, Latinos were contracting COVID-19 at higher rates than the rest of the population. Yet, little to nothing was being done to address this rise in cases until Hispanic/Latinos made up 52% of cases in Van Buren County despite only comprising 11.7% of the population. It angered me to learn that during the initial surge of COVID-19, Hispanics/Latinos, people like myself and my family, were five times more likely to die from COVID-19 compared to white people across the nation. I remember frustratingly asking myself, “given that the coronavirus can affect virtually anyone, why does this disparity exist?” The answers I came across reflected the common themes that exist among minority health disparities such as poor access to health care, essential-worker occupation status, unsafe working environments, and crowded housing. However, it is important to recognize that these disparities are not a product of individual choices as many often believe, but rather stem from exclusionary policies and intentional discrimination that is deeply rooted in the history of our nation. To prevent and reverse the effects of health disparities, we need more than what medicine and public health can provide. Rather, we need to travel back in history to understand how current day disparities came to be, including the disproportionate effects of COVID-19 in the Hispanic/Latino community.

Latinos have a longstanding history of holding jobs that are crucial to the development of this nation and the economy. In the early 1900s, Mexican immigration increased due to the demand of the agricultural and railroad industries, which resulted in many immigrants working as low-wage laborers. However, their arrival was not celebrated but was marked by racism as they were labeled as racially inferior and less intelligent than white people, which also influenced the types of jobs that immigrants were able to access. These sentiments then led to their poor treatment, such as being seen as sources of infection, despite their instrumental work in the labor force.

When a typhus outbreak occurred in 1916 in Los Angeles County among 22 Mexican railroad workers, all efforts to address the outbreak were aimed at improving Mexicans’ personal hygiene rather than addressing the poor working and living conditions, reminiscent of the treatment of the disproportionate numbers of COVID-19 in the Latino community. Rather than focusing on ensuring that there was proper personal protective equipment for essential workers or centering efforts on providing adequate housing for quarantining, most interventions revolved around “fixing” prevention behaviors such as wearing masks and maintaining social distance.
Crowded and substandard housing as a predictor for negative COVID-19 related outcomes also has its roots in history. In the 1930s, the Home Owners’ Loan Corporation (HOLC) offered insured mortgages for homeowners. However, in order to determine if homeowners could qualify for the mortgages, neighborhoods were designated as non-risky or risky, with those deemed “risky” labeled as red. Not coincidentally, these redlined areas mapped on to neighborhoods where Black and foreign-born residents primarily lived, thus preventing and dissuading homeowners from buying homes in these areas. This discriminatory practice led to homeowners living in these redlined areas unable to access these government-backed loans, which led to people of color often unable to independently own homes and thus crowding multiple people under one roof. Although redlining was deemed illegal after the passing of the Fair Housing Act in 1968, we still see its effects due to government disinvestment in historically redlined neighborhoods, which has manifested as poorer health outcomes in its habitants. Thus, the disproportionate number of cases due to COVID-19 is not due to Latinos living in multigenerational homes by choice, but likely a result of being segregated into redlined areas with limited economic opportunities and crowded homes that prevented them from properly quarantining and maintaining social distance.

Finally, an important policy that impacted the Hispanic/Latino community was the longstanding “public charge” rule. Historically, this rule has served to prevent people from immigrating to the United States from its enactment in 1891, when immigration was booming in America, by identifying people who were likely to rely on government benefits. This exclusionary policy underwent several iterations, and in 1996, barred legal immigrants from accessing public benefits. However, after 5 years of this exclusionary policy, benefits were again reinstated for immigrants. In February 2020, the rule underwent a significant change under the Trump administration such that it again would evaluate an immigrant’s ability to apply for U.S residency or citizenship by determining if the applicant were “likely” to rely on assistance programs, such as Medicaid. This led to a chilling effect in the Latino community such that many people dropped their benefits and avoided accessing healthcare services out of fear of being considered a “public charge.” This had significant implications during the pandemic as this ruling contributed to reduced access to medical care and decreased acceptance of COVID-19 vaccines, further perpetuating health inequities.

Through these examples, we see how to really understand the disparities we witness today, it is imperative to go back in time and understand the historical context. Medicine can help with symptoms, public health with prevention, but only history can help us to dismantle structural racism by first identifying it then pulling out its roots. To prevent a disproportionate burden of disease among the Hispanic/Latino community as we saw in the pandemic, we must tackle discriminatory policies, such as the “public charge” rule, provide quality housing, support communities’ economic well-being, and create safe working-environments starting with what we know of the past. Then, hopefully, through the acknowledgement of our past, we can create a more equitable and just future.
I sit at her bedside watching her mumble to herself during yet another hospitalization. It feels as though I can see the delirium take over her mind as we sit in a windowless ED room waiting for the CT scan results. Over the years, I have watched my grandma’s dementia slowly creep in and consume her life, like a permanent dark cloud on a sunny day. As a medical student, and the first (future) physician of my family, I can name the epidemiology, pathophysiology, and medical treatments for Lewy Body Dementia. Yet, I feel powerless and frustrated by the disease that continues to take my grandma from me.

It began with hallucinations.

"Want to hear something weird, Serene? There were birds flying over my bed this morning!"
"Oh Teta*, you were probably just dreaming."

Then, the short-term memory loss and anger.

"Teta, I noticed you’ve been wearing the same dress for the past two days. Did you maybe forget to shower?"
"How dare you ask me a question like that? Of course I showered."

"Teta, did you take your medication today?"
"Of course I did."
"Why do you still have pills in your medicine box?"
"The pharmacist probably filled too many pills."

Eventually I started putting a new set of clothes next to her shower every night, allowing her to believe that she had put them there herself the night before. I crushed her medication into her food to avoid reminding her that she forgot her pills once again.

All in an effort to protect her pride.

Teta’s memory and hallucinations worsened and consequently the medications were increased to subdue her progressive symptoms. The quetiapine dosage was first increased, then it was taken from once a day to twice daily. When her symptoms persisted, her nighttime dosage was doubled. Then memantine was added to manage
her tremor and shuffling gait. Bupropion was also added to the mix to help with her depression and poor appetite.

As the medications and their dosages increased, her energy went down. We had to choose between retaining her energy and allowing the hallucinations to consume her mind, or putting her mind at peace while her muscles deteriorate as she lay bedridden.

I watched her independence with activities of daily living (ADLs) decrease while the caregiver burden simultaneously consumed my parents. Every meal, every trip, every day revolved around Teta's care. They say hypertension is a “silent killer”, but dementia is quite the opposite - it’s a loud, obnoxious disease that we have barely uncovered.

Aging is a strange thing. A person’s body slowly meets its quota, one organ after the next. Throughout most of our lives, we are congratulated on meeting milestones: gross and fine motor skills as children, academic accomplishments as adolescents, and eventually career milestones as adults. Along the way, many of us also find joy and meaning in watching the next generation grow. There reaches a tipping point however where, often unbeknownst to us, regression starts to sink in. In some cases, this leads to a stage where as adults we begin to rely on others, requiring nurture and care similar to our early infancy.

We are not taught the art of coping with age in medical school, so how can I expect my patients and their caregivers to accept the progression of a healthy, capable body being taken over by disease?

I barely understand it myself.

"Teta" means grandmother in Arabic.
Discharge planning is a topic that has often come up on rotations for hospitalists. From involving patients in their care from the medical diagnosis admittance in the hospital to discharging the patient, discharge planning begins on day 1. A model used by rehabilitation professionals, such as Physical Therapists, supports the ICF model (Figure 1) to develop a framework for the patient to account for factors to consider for discharge planning.¹

Figure 1: ICF Model¹

Discharge destinations (Figure 2) depend on the level of function, overall health, and assistance the patient may need.² Involving physical and occupational therapy in the patient’s care can expedite the planning process. Appropriate social work and case management can provide support services for the patient and tentatively plan for potential discharge after the hospital stay. This list is not inclusive as there are discharge destinations that merit further medical management, including tertiary care and home discharge, which may involve outpatient follow-up or home health.
When completing the discharge summary for patients in the hospital setting, this essay provides some tenets to consider during the initial intake of a patient upon admission. Involving the appropriate support staff and educating patients will ease the transition toward discharge.⁴

**References**


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A Reflection and International Perspective on Medicine-Pediatrics

Katia Yazji
MS3, The Royal College of Surgeons in Ireland

During my pediatrics clerkship, I was attending an outpatient adolescent medicine clinic with Dr. E in North Dublin. Dr. E was scanning through the patient list for the afternoon when she saw the next patient’s name and told me, “This is going to be a sad one for me.” Unsure of what she meant, I anticipated that the patient may have a debilitating illness or a relapsing condition, which I tried to brace myself for emotionally.

I walked into the waiting room to call the patient in, and a 16 year old boy named T with Trisomy 21 skipped joyfully into the consultation room with his mother speed-walking to catch up behind him. Dr. E asked T and his mother how he was getting along, how he was doing in school, and if he has been following up with his various health screening appointments. T was very happy to share that he has taken up horseback riding and named his horse, “Green Cracker.” His mother responded to Dr. E saying, “For the first time, I really have nothing to say. He’s been doing so well and we’ve had no concerns.” Behind the facemask, I noticed Dr. E’s smile slowly fade away. Dr. E let T and his mother know that since he was 16 years old, he would be discharged from pediatrics back to his family physician and transitioned into adult care.

T’s mother then began profusely thanking Dr. E for all of the years she took care of her child since his time in the NICU. As they were heading out of the door, T turned around and said to Dr. E, “Can I give you a hug?” Dr. E replied with a resounding, “Yes of course!” After hugging her, he said to her, “Thank you very much for everything. I love you.”

Dr. E’s glasses fogged up behind the facemask. After T left the consultation room, she became tearful. She shared with me that she was the resident with the attending physician when they had given T’s mother a post-natal diagnosis of Trisomy 21. She was also the physician who happened to be at most of his appointments as a resident and later became his pediatrician when she completed her fellowship. Before welcoming in the next patient, Dr. E said to me, “I wish I didn’t have to discharge T from my service.”

Medicine-Pediatrics is not currently a specialty that is offered in Ireland and most of Europe. To me, this experience underscored the value and unique perspectives that Medicine-Pediatrics physicians can offer to families.

In a poetic sense, Dr. E and T both “grew up” together. She met him at his birth and continued to care for him throughout his childhood as she progressed in her training and became an attending physician. As an aspiring Medicine-Pediatrics physician, I hope to have the opportunity to “grow up” with my patients and build these meaningful life-long relationships with them as their medical provider.
With the goal of vaccinating our community’s most vulnerable members, a team of four medical students and community psychiatrist, Dr. Sunny Aslam, offered the COVID vaccine in homeless shelters, a free-meal distribution site, group homes, areas where unhomed individuals congregated outdoors, and knocked door-to-door in subsidized housing neighborhoods offering the vaccine throughout the summer of 2021 and early months of 2022. Our team traveled Syracuse by means of Dr. Aslam’s private vehicle, approaching countless individuals with the question “have you had your COVID vaccine yet?” Anyone wishing to receive the vaccine could receive it right then - in the shelter cafeteria, on the front stoop of an apartment building, or sitting on a curb on the outskirts of a quiet parking lot. One of our students would retrieve the vaccine from our styrofoam cooler, while another used a smartphone for complete digital documentation. When folks had questions about the vaccine or were concerned about misinformation they had heard, we sat and talked with them, answering each of their questions and gently encouraging vaccination if they were ready. Some of these conversations would continue week after week, as we returned to the same shelters and street corners. Building a rapport with the community and gaining recognition, more people started accepting our offer. Folks who had originally been hesitant became our spokes-people telling their friends “I didn’t feel too bad after my shot, you’ll be alright, just do it!”

As we offered the vaccine, we heard numerous stories about the ways in which social determinants of health acted as barriers to vaccination. People shared challenges related to transportation, working hours, hesitancy based on misinformation, and concerns relating to co-morbidities. Through these conversations we witnessed firsthand how impactful community-based outreach can be, especially among populations who have mistrust in the medical community rooted in historic injustices.

Our mobile vaccine clinic was able to reach hundreds of individuals, vaccinating nearly 200 people, while initiating contact with representatives from the healthcare system for hundreds more. Health promotion and education are a pillar of public health philosophy because none of our interventions, screenings, or policy-based attempts to promote community health can be successful without building health literacy and developing trusting relationships within our communities. To increase health equity, it is essential that policy is expanded to support community-based health services and strategically work to repair mistrusting relationships between marginalized groups and the healthcare system. Med-Peds physicians are uniquely positioned to participate in
community-based wellness initiatives for patients across the lifespan. We encourage future Med-Peds physicians to consider the ways in which you can meet the needs of your patient population through community-based interventions.
Discouragement; Encouragement

John Nelson
MS3, University of Iowa, Carver College of Medicine

I was going to write an essay on why practicing medicine is hard. Certainly, there are days when it is. Some days I come home and could practically collapse. But I don’t feel like that all the time. For instance, as I write this I feel pretty good. I enjoyed my day. I enjoyed the people I worked with. I enjoyed solving the problems that presented themselves. I enjoyed the diagnostic challenges.

It turns out that it is hard to write about feeling discouraged when you feel optimistic.

But even if I cannot, at this moment, find it within myself to write the paper I set out to write, perhaps I may write a better one. The same gift of gentle optimism and peace that I am blessed with today allows me to look back with a little clearer perspective on the experiences that have previously left me feeling discouraged. My goal today is to consider what makes me discouraged, what makes me encouraged, and perhaps to reflect on the implications of these revelations.

Discouragement.

“I don’t know”, I say, as my voice grows timid and my mind seems to disassemble itself in search of an answer. I should know. I know I should know. I know I used to know. I was just thinking of it yesterday. But alas, it’s not there. I feel discouraged.

My senior resident is staying late to help me. Again. He assures me he’s doing no more than he would do if I were an intern. But I only have two patients. Can’t I at least work efficiently enough that people don’t have to stay late to make up for my failings? I feel discouraged.

Another team member jumps in to help me with a patient. He asks the questions, he does the physical exam, he lists off orders for me to place. I stand back, I watch, I realize that he does so many things I would have forgotten to do if I were alone. He must sense that this was beyond my ability. Why else would he jump in and do what is supposed to be my job? I feel discouraged.

Then some days, I walk back to my computer and sit down to document. My eyes glaze over as I resist. I don’t want to type. I’m tired. Is this really necessary? Each keystroke feels like a burden, let alone the mental effort to actually decide what to type. My brain turns to messages I’ve heard many times about how important it is to be knowledgeable, efficient, punctual, empathetic, kind, resourceful, responsive, and generally a human being above reproach. The
combination of weariness and expectation makes me feel especially discouraged.

Discouragement comes from many places. But I hope you see, as I can in moments of clarity, that these discouragements are built from falsehoods of one form or another. I will always be learning, thus "I don’t know" can be a perfectly appropriate answer, even an admirable one. People stepping up to help me is a sign of their kindness, not my helplessness. And it is perfectly reasonable to expect to feel tired and to make mistakes. But maybe, if I own up to them in humility there is even good that can come from that. I know that I have seen others adopt these perspectives and good does come of it.

Encouragement.

I call a consult. I feel confident in how I’m describing the patient, I don’t have all the details memorized but I know where to find them. I hang up the phone feeling like the consulting service respects me for the detail I’ve provided and the specific nature of the question I am asking. I feel encouraged.

I have a clinical suspicion. I present a plan to work it up in more detail. My attending agrees with my plan. That in and of itself is encouraging. But then, once in a while, my suspicion is correct. I could practically shout for joy. I know I’m growing.

I go a whole conversation without feeling timid or stumbling over the medical terminology. I felt like it was a real conversation with someone who knows what they are talking about. I am encouraged.

I finish my notes a little faster than I could a few weeks ago. I feel encouraged.

I find that I’m laughing and talking freely with the residents rather than silently stressing about appearances. I feel like I belong. I feel encouraged.

I talk with a patient. I realize they don’t understand what’s happening. I explain it to them. They express relief to finally understand what’s going on. I feel encouraged.

I’ve been working with a patient for 4 or 5 days in the hospital. They greet me with a smile when I come in to pre-round. I feel encouraged.

The attending wants me to lead the family meeting. Even if I’m nervous, I recognize it’s a great expression of trust. I feel encouraged.

I run into a clinical circumstance that I just studied a few days ago. I get to apply what I was studying. I feel encouraged.

My senior compliments me. Sometimes on my notes, sometimes on how I talk with patients. I feel encouraged.

I’m given some feedback and, after applying it, I’m praised for listening. I feel encouraged.
Encouragement is a funny thing. Sure, there are large events that are grand and feel fantastic. But, most of the time, it’s small things, small moments, that add up to a general feeling that the day went well. It takes attention to see those small moments and to appreciate them. And often times, they only come after some investment. I wouldn’t get that smile from my patient if I didn’t take the time to listen to them. I wouldn’t have the trust of my attending if I didn’t show up prepared. I won’t be able to make that diagnosis unless I’ve been studying.

Conclusion.

There is plenty of opportunity for discouragement and encouragement in medicine. Successes and failures must both exist. Joy and sadness. But perhaps by investing in the ideals we hope for, balanced with expectations based in reality, we can find encouragement and peace a little more frequently. And perhaps discouragement may be a little less potent when it comes. And maybe living this way might allow us to bring a moment of encouragement to someone else’s day. I certainly hope so.
The Perspective

Code Blue a Haiku

Anthony Conforti, MD
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The bells ring “Code Blue”
Compressions begin, trach tubed
How could it be you?
Health Disparities During COVID-19

Erica Riddick
MS3, Drexel Medicine

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman..."
– Dr. Martin Luther King Jr.

When I initially heard this quote as a young child, I did not fully grasp the gravity of the statement. However, as an adult, and more importantly as an African American medical student, I have gained clarity through many personal experiences. Throughout my childhood, I lived in the rural south. As I observed firsthand the drastic differences in both health care and education between my community and others, I began to understand health disparities and the significant role they played in many people’s lives. Historically, socioeconomically disadvantaged communities suffer disproportionately in terms of health care. They tend to have less access to proper care, and they often report feeling mistreated once care is received. Additionally, it is well documented that health care providers’ implicit biases may negatively affect certain patients’ treatment and outcome. These issues, and many more, contribute to the disparity in health care between marginalized groups and their counterparts.

Unfortunately, the COVID-19 pandemic, like many other illnesses, impacted these vulnerable communities most severely. Low-income and disadvantaged populations struggled immensely throughout the pandemic. I vividly remember when the government began suggesting that everyone work from home to protect themselves from transmission. For many members of underprivileged communities, this was not feasible. These individuals often work in essential positions, such as retail and the food industry. Therefore, the most vulnerable populations were forced to work on the front lines, increasing their risk of contracting COVID-19 even further. Additionally, many members of these communities lack adequate health literacy. This caused confusion throughout these populations regarding virus prevention and transmission. This same lack of health literacy also coincides with the decreased preventive care practices in these populations. Because of this, chronic conditions such as diabetes, kidney disease and hypertension disproportionately impact these communities, increasing their risk for COVID-19 complications.

Furthermore, the lack of access to proper COVID testing among disadvantaged communities became apparent to me after a heated conversation with my mom. I remember answering my cell phone to her frightened voice, asking, “So where can I get tested? Everyone keeps talking about this virus, and I want to know if I have been exposed, but I just don’t know where to go.” I listened to her, frustrated, as she shared her concerns with me. She could not understand why I, a resident of a developed, metropolitan area like Philadelphia, had access to multiple testing sites, while she, living in rural Mississippi, had none. After this difficult conversation with my mom, I began to research further, and I discovered that underprivileged and low-income communities had far fewer testing sites per square mile than more affluent communities.
Members of disadvantaged groups also had less opportunity to properly adhere to social distancing guidelines. Many of these individuals lack stable transportation; thus they were forced to continue taking public buses and trains despite the COVID-19 pandemic. Additionally, many school systems assumed that all students had access to updated technological services, such as computers, iPads and working Wi-Fi. The transition to remote education negatively affected many disadvantaged families while benefiting their counterparts with healthy home environments lacking distractions. Students from marginalized groups struggled to remain up to par with their classmates due to these drastic differences in the resources accessible to them.

All of these factors played a key role in the disproportionate impact that COVID-19 had on socioeconomically disadvantaged communities. As we move forward as a society, similar deep-rooted issues also impact vulnerable populations’ perspective on the COVID-19 vaccine. Many members of these populations are understandably wary of taking the vaccine that was recently made available. In the past, certain marginalized groups, especially African Americans, were mistreated by the medical community. During the Tuskegee Syphilis Study, Black men were denied treatment for syphilis, even though a cure was readily available. This, as well as other incidents has impacted this community’s view of the medical profession. It is essential that health care providers show empathy and understanding when discussing the vaccine with members of these populations rather than wrongfully judging them for refusing it.

In today’s society the health care that individuals receive may differ based on race, ethnicity, social status and even zip code. The COVID-19 pandemic has disproportionately impacted vulnerable communities, and it has highlighted the many barriers that disadvantaged groups often face. As a future health care provider, it is important to me that I, and my peers, remain educated about health disparities and the communities they most affect. Although the medical profession is currently far from perfect, I am confident that the physicians to come will ensure that all patients are treated equally and justly. Now, as I ponder Dr. Martin Luther King Jr.’s quote, I am feeling determined — now more than ever — to serve as an advocate for marginalized groups, like my very own.
Scimitar Syndrome: A Rare Cause of Pulmonary Hypertension In An Adult

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Introduction:
Partial anomalous pulmonary venous return (PAPVR) is a congenital anomaly resulting in left-to-right shunting, in which one or more (anomalous) pulmonary veins return to the right-sided circulation instead of the left atrium. Scimitar syndrome is a known subtype of PAPVR in which the anomalous pulmonary vein(s) drain the right lung into the inferior vena cava (IVC).

Case Presentation:
A 38-year-old female with a history significant for morbid obesity presented to the clinic with shortness of breath. She had been previously diagnosed with asthma, and her pulmonary function testing was consistent with the same. Physical exam was notable for a wide and fixed splitting of S2, raising suspicion for an atrial septal defect (ASD). She was then referred to cardiology and was found to have pulmonary hypertension (HTN) on cardiac catheterization (i.e., the pulmonary flow being 2/3rd the systemic flow, with Qp/Qs of at least 2.7 - 1), along with the presence of an anomalous pulmonary vein (scimitar vein) draining the right lung.

A computed tomography (CT) scan demonstrated the scimitar vein draining all right-sided pulmonary venous blood to the inferior vena cava. The scan also showed a sizeable systemic artery supplying a portion of the lower lobe of the right lung, penetrating the diaphragm and bifurcating reasonably early. This anomalous artery appeared to arise from the right hepatic artery.

Given the patient's complex congenital anatomy, morbid obesity, and symptomatic pulmonary HTN, she was referred to a pediatric cardiothoracic surgeon at a children's hospital for surgical repair. Intraoperatively she was noted to have a severely enlarged right atrium and right ventricle. The right pulmonary veins (i.e., scimitar veins) were amputated off the IVC, and blood flow from the right lung was redirected to the left atrium. The systemic artery arising from the hepatic artery was ligated and tied off multiple times. This portion of the lung's right lower lobe (supplied by the systemic artery) was amputated/excised. She also underwent ASD repair during the same procedure.

Postoperatively she did well. A follow-up transthoracic echocardiogram one year later showed normal biventricular function, and pulmonary flow was now 1/3rd the systemic flow.

Discussion:
Scimitar syndrome is a complex and rare association of congenital lung and cardiac abnormalities. It involves an anomalous pulmonary venous return to the inferior vena cava, typically draining the right lung \(^{(1)}\). The name is derived from the curved Middle Eastern, or Turkish sword called “Scimitar,” roughly resembling the shape of this right anomalous pulmonary vein on the frontal chest radiograph \(^{[2, 3]}\). The estimated prevalence is 1 to 3 per 100,000 births, with a 2:1 female predominance \(^{(1, 2)}\). This entity was first described in London in 1836 during
The autopsy of an infant. The first surgical repair was performed in 1956 using cardiopulmonary bypass on a patient with a scimitar vein and an ASD.

Commonly associated cardiac defects include ASD (80%), followed by patent ductus arteriosus (75%), ventricular septal defects (30%), pulmonary vein stenosis (20%), and rarely, hypoplasia of both the right pulmonary artery (RPA) and right lung, earning it the name of congenital venolobar syndrome (1,2,3).

Two primary forms have been described: Infantile and childhood/adult (2). The infantile variant has a higher incidence, comorbidities, and mortality rate. This form is generally diagnosed within the first year of life, and patients typically present with failure to thrive, tachypnea, and heart failure. If severe pulmonary hypertension exists, cyanosis may occur from right to left shunting. Mortality is as high as 45%. In such patients, the pulmonary to systemic flow (Qp/Qs) is always >1 (unless Eisenmenger physiology has developed) (2).

The childhood or adult form is less severe and may remain asymptomatic for the longest time. Some diagnostic clues include frequent chest infections confined to the right lung, unexplained right heart dilatation, and occasionally chest radiographs showing abnormal vascular and bronchial markings on the right side. Right ventricular hypertrophy and right bundle branch block can occur in up to 50% of patients. The Qp/Qs is usually about 2:1 (2).

Diagnostic workup includes obtaining a transthoracic echocardiogram; Magnetic resonance imaging (MRI) and computed tomography angiography (CTA) are helpful tools to delineate the vascular anatomy, bronchial tree, and cardiac chambers (2). A phase contrast MR may be helpful in calculating Qp/Qs, which may help guide further decisions on surgical repair (3). Cardiac catheterization and angiography are the gold standards for not only confirming a diagnosis of scimitar syndrome but also detecting any additional systemic arterial collaterals from the thoracoabdominal aorta to the lungs, anatomy of the pulmonary artery, degree of intracardiac shunting, and the specific course of the anomalous pulmonary venous drainage (2).

Treatment (in the childhood/adult) form of Scimitar syndrome includes surgical repair in a symptomatic patient or when the Qp/Qs is >1.5 in otherwise asymptomatic patients (2). Those patients with mild symptoms and Qp/Qs of ≤1.5 are managed medically to control/prevent pulmonary HTN (3). Surgical treatment may be pursued by two different approaches: Either resecting the lung drained by the scimitar vein or rerouting right lung venous drainage to the left atrium (by creating an intracardiac baffle via a tunnel or direct re-implantation with or without circulatory arrest). In both options, the abnormal systemic arteries to the lung should be ligated, and other cardiac lesions should be repaired. However, residual scimitar drainage stenosis, which may require reintervention over time, is a critical problem irrespective of the surgical approach (2, 3).

Conclusion and take-home points:
1. Scimitar syndrome is a rare congenital cardiopulmonary disorder that involves a congenital anomalous right pulmonary venous return to the IVC.
2. The scimitar sign is the characteristic appearance of this anomalous vein on the chest radiograph (i.e., appearing as the curved Turkish sword, ‘Scimitar’).
3. It has various presentations, including dyspnea on exertions, recurrent chest infections, pulmonary arterial HTN, and rarely hemoptysis.
4. Initial diagnosis requires a TTE, MRI, and CT to delineate the exact anatomy. The gold standard remains cardiac catheterization.
5. Treatment is medical or surgical, depending on the symptoms and the Qp/Qs ratio.
The Perspective

References:
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