Summer 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,

A belated, but still warm welcome and congratulations on starting another academic year! To all our new interns, welcome to the Med-Peds community! Across the country, I can definitively say we’re all excited to see you start your journey to becoming a Med-Peds trained physician, and can’t wait to see all the things you’ll do in the next four years! To all our continuing residents and faculty, here’s to another great year of being Med-Peds!

Things have been busy in the few short months since our new officers stepped into their new positions! By the time you’re reading this letter, we’ve already wrapped up this year’s Medical Student Recruitment Informational Webinar series. We also had our annual program spotlights where we had program directors and current residents from around the country take some time to say what they love most about where they work and live! We hope that you’ll see that no matter where you go for residency, Med-Peds is an exceptional specialty (and community) to be a part of. Despite the packed schedule, we also managed to fit in a Med-Peds Hospitalist career webinar with many Med-Peds alumni taking time out of their busy schedules to help mentor the next group of aspiring Med-Peds hospitalists. A huge thank you to every person who made time to be a part of all these webinars! If you missed any of these webinars, don’t worry! We recorded them and they’re available on our website at https://medpeds.org/253271-2/. And stay tuned for our communications about upcoming virtual open houses and DEI webinars across the country.

I’ve been blessed to have the chance to work with an incredible group in this year’s NMPRA Executive Officers and Board of Directors. I’m truly excited for you all to see what we have in store for this academic year. Some hints that I’m allowed to say...We’re working on expanding the Med-Peds themed merchandise we have available in our online store: https://www.bonfire.com/store/nmpra/. We’re also working on rolling out a communication platform for all our MS4s applying for Med-Peds residency this year and current residents (more info to come). And finally, I’m delighted to announce we have finalized the venue for our upcoming 2023 national conference! We will be at the Westin DC City Center in Washington DC on October 21-22, and our theme will be “Med-Peds in Health Equity and Advocacy”. Our specialty was born out of a desire across the country to be able to do more for our patients in both the pediatric and adult worlds, and I can’t wait for you to see what Med-Peds physicians are doing across the country right now to bring high quality care to our patients across the age spectrum. Registration is open now (https://medpeds.org/about-nmpra/national-meeting/) and we hope to see you there!

Best regards,

Stephanie Lee, MD
Internal Medicine-Pediatrics | PGY-4
University of Miami/Jackson Health Systems
President | National Med-Peds Residency Association
Welcome everyone to the start of new academic year! For me, the new academic year means meeting with all the new first year residents, finding new books to put on my reading list and taking vacation. This year, I am planning on going to Amsterdam and surrounding areas.

At the beginning of August, the AAP Leadership Forum was held at AAP Headquarters. This conference brings together AAP Board of Directors and leadership as well as representatives from Chapters, Committees, Sections, Councils and the 10 AAP Districts. The conference had rigorous discussions on issues central to the care of our patients and our communities. Examples include children’s mental health needs, protecting children against gun violence, DEI advocacy and advancing health equity, and healthcare issues central to children and young adults. The conference culminated in the “Top 10 resolutions” which will be published in the AAP news (www.aapnews.org). The resolutions included topics ranging from education and training in firearm safety discussions and autism diagnosis to addressing equitable access to healthcare, to supporting financial reforms. Absent from the Top 10 was Physician Wellness, which means the Section on Med-Peds will be increasing awareness of this topic more than ever as it remains vitally important for all of us.

A powerful discussion led by Dr. Kemia Sarraf gave an engaging and poignant discussion on “Health Equity, EDI, and Physician Well-being and Safety” which gave an insightful perspective of our work for health equity and EDI and the interplay to physician well-being and safety.

During one of the evening AAP networking events, we were able to watch the documentary, Toxic: A Black Woman’s Story, which focused on the health disparities and inequalities in our healthcare system for pregnant women of color and infant loss, and what needs to be done to address them. As the film was created in Cuyahoga County, Ohio, I was left with thoughts on how I can increase awareness, address the structural racism and factors that impact infant loss, and be an advocate for my patients and my community.

Finally, get ready for the AAP National Conference in Washington DC. This will be a great time for advocacy! Register now (https://aapexperience.org/conference-registration/)! The Physician Health and Wellness Booth makes a grand return and we need volunteers! See the flyer in this edition of Perspective. If you would like to volunteer for the Physician Wellness booth, please let me know (mdjbarr248@gmail.com).

Our educational session will be a joint program with the Section on Simulation and Innovation Learning Methods (SOSILM). This promises to be a fun experience with a focus on technology and
informatics in the clinical and teaching settings. NOTE: Instead of a reception after the program, we’ll be taking a 1-hour lunch break. The lunch is sponsored by NMPRA and SOSILM. Thank you! See a copy of the program in this edition of Perspectives.

There have been a large number of submitted abstracts, which will make for an exciting poster and networking session.

We are kicking off a new communication to Section members, which will be a seasonal update on what Section members are up to and other timely information about Med-Peds. If you are interested in serving on the editorial team, please contact our staff Jackie Burke at jburke@aap.org.

This is going to be an exciting academic year for all of you as well as for the SOMP. The Section of Med-Peds is looking for ways to increase our engagement. We continue to partner with NMPRA for the DEI mentoring program as well as updating the Med-Peds 101 to provide information for clinicians. Continue to check out our collaboration site (members only) at https://collaborate.aap.org/medpeds/Pages/default.aspx

Jayne

Jayne Barr MD MPH
Chair, AAP Section on Med-Peds
Greetings NMPRA community!

September marks the start of an exciting time for our Med-Peds residency programs across the country! ERAS opens at the end of the month and will introduce our programs to the next generation of Med-Peds residents. We are excited to get to meet the individuals that will comprise our Med-Peds classes of 2028!

Throughout the summer, the MPPDA Recruitment Committee hosted various program spotlight and special topic webinars for students across the US who will be applying to Med-Peds in this upcoming cycle. A special thank you to Drs. Allison Ashford and Nate Stehouwer for leading our MPPDA Recruitment Committee’s efforts over the past year! They were also pivotal in helping the MPPDA Executive Committee draft our 2023-2024 recruitment recommendations which have helped set clear and transparent processes for programs and applicants.

Even though programs throughout the country are focusing on interview season, we cannot forget about our various upcoming meetings that will allow us to come together and enjoy learning and fellowship as a Med-Peds community. We are excited to see many of you at the upcoming NMPRA annual meeting at the AAP National Conference and Exhibition, and then come together as a Med-Peds residency education community at our annual MPPDA Meeting that will occur in conjunction with Academic Internal Medicine Week 2024 in April in Columbus, Ohio. I’m sure lots of exciting karaoke adventures will be experienced at both meetings!

We wish all of those applying to Med-Peds the best of luck in the upcoming recruitment season! Students, please don’t hesitate to reach out to your local program directors (or any others from across the country if you don’t have one locally!) for help or advice.

In closing, I leave you with some wise words from the esteemed Dr. JT Tolentino – “It’s always a great day to be Med-Peds!”

Warmly,

Jennifer O’Toole, MD, MEd
MPPDA President, 2023-2024
Med-Peds Program Director
University of Cincinnati College of Medicine and Cincinnati Children’s Hospital Medical Center
The NMPRA 2023 National Meeting
October 21-22
Westin DC City Center, Washington, D.C.

~Theme: Med-Peds in Health Equity and Advocacy~

Full Conference Agenda coming soon
Day 1: Saturday, October 21st (Main conference day)
Day 2: Sunday, October 22nd (Geared towards medical students)

Register here: https://medpeds.org/about-nmpra/national-meeting/
We accept payment through PayPal and credit card.

*Note: Group Discount Registration is available! If 3+ residents are coming from the same program or a medical student interest group is sending 3+ members, we’ll take 15% of the total group rate. To register, just email treasurer@medpeds.org and we’ll get you set up!
AAP Alerts

H3022: Joint Program: Section on Simulation and Innovative Learning Methods (SOSILM), Section on Internal Medicine and Pediatrics (SOMP), and Committee on Continuing Medical Education
The Medical Educator's Digital Toolbox
Sunday, October 22, 2023

9:00 AM  SOMP Oral Presentations
Moderator: Kristin Wong, MD, FACP, FAAP

9:35 AM  Introductions: Welcome From SOMP and SOSILM for Joint Program*
Moderators: Kristin Wong, MD, FACP, FAAP; Dennis Daniel, MD, FAAP

9:40 AM  Telehealth Best Practices for the Professional and the Learner
David Kaelber, MD, MPH, FAAP

10:15 AM  Social Media in Medicine
Toby Terwilliger, MD, FAAP

11:00 AM  Expert panel, Q&A
Moderator: Kristin Wong, MD, FACP, FAAP
Faculty: David Kaelber, MD, MPH, FAAP; Toby Terwilliger, MD, FAAP

11:30 AM  Lunch*

12:30 PM  Digital Educator’s Toolbox (Small Group Break-Out Sessions)
Moderator: Dennis Daniel, MD, FAAP
Faculty: Traci Wolbrink, MD, MPH, FAAP; Tony Tarchichi, MD, FAAP; Rahul Damania, MD; Patricia Tran, MD, MS, FAAP

2:00 PM  SOMP adjourns to Poster Hall*
Poster viewing from 2:30 to 3:30 PM

2:00 PM  SOSILM Meeting*
Moderator: Marjorie Lee White, MD, MPPM, MA, FACEP, FAAP

2:10 PM  The Lou Halamek Pediatric Simulation Excellence Award*
Award Presenter: Lou Halamek, MD, FAAP

2:30 PM  SOSILM Oral Presentations
Moderator: Theodora (Lola) Stavroudis, MD, FAAP

3:00 PM  SOSILM adjourns to Poster Hall *

*This portion of the agenda is not designated for CME credit.
AAP Alerts

Services Provided

NCE attendees can have a walk-up one-on-one discussion with a Med-Peds doc to talk about his/her own personal health and wellness.

Resources Available (paper or code)

- Adult Preventative Healthcare Checklist
- 15-Minute Bodyweight Workout
- Best Wellness Apps
- Wellness Learning Plan
- Well Woman Chart
- Clinical Report: Physician Health & Wellness
- Digital Detox
- Physician Support Line

FREE GIVEAWAYS!

HOURS AND LOCATION

EXHIBIT HOURS:

Saturday, October 21
12:15pm – 4:00pm, 5 - 6pm

Sunday, October 22
10:00am – 4:00pm

Monday, October 23
10:00am – 2:00pm

Walter E. Washington Convention Center Exhibit Halls A, B and C (Booth #1541) in the AAP Resource Center

IF YOU ARE INTERESTED IN VOLUNTEERING IN THE BOOTH TO DO ONE-ON-ONE’S WITH NCE ATTENDEES (FREE EXHIBIT HALL REGISTRATION INCLUDED) PLEASE CONTACT ABHI SURAMPUDY AT Abhishek.Surampudy@christianacare.org
The adage of "You don’t know what you have until it’s gone" became glaringly obvious to me these last few years of my residency training. During my intern year, I submitted a perspective to the Greater Louisville Medical Society titled, “MICU Reflections During the Peak of COVID-19”. Then, I knew a lot less than I do now. Like how that point in time (March 2020) was nowhere near the peak of COVID, but only just the beginning. And how raising two young children is a heck of a lot different than raising just one. But finally, how important it is for me to be in the presence of my patients and colleagues.

I closed that perspective piece by expressing my trepidations regarding society’s “new normal” following the pandemic and how we would adjust. The primary care field was largely forced to transition as many visits as possible to the telehealth platform. In doing so, I was robbed from being truly present for my patients. This takes me to the best part of my workday: having the ability to interact with my patients in person.

Just like many of my colleagues, I went into medicine to serve others. Learning the art of medicine during the pandemic was certainly not what I signed up for. Similarly, participating in virtual encounters was never something I thought I would have to accommodate to during my residency training. The physicians I always looked up to and admired as a young aspiring pre-med student were the ones with the best bedside manner and the most remarkable longitudinal rapport that is palpable as soon as you walk into the patient room. As a Med-Peds resident, our specialty is focused on being at the bedside of patients and I firmly believe that’s where we belong, despite how much charting and documentation occurs in physician workrooms.

Our patients need us by their side. It is critical that we are there to assess any clinical changes, answer their questions, provide reassurance, and be a comforting shoulder when delivering a difficult diagnosis. In the outpatient setting, I believe there is something special about being emotionally, mentally, and physically present for our patients. In my mind, this is at the core of being a physician and essential to practice good medicine. On a personal level, I could feel an immeasurable absence during virtual encounters. In some ways, I felt that I was straying away from being the type of provider I envisioned myself being – one that is there for his patients. I obviously understood the importance and necessity of these virtual visits, but it was something I learned to adjust to with time and practice.
In response to my self-reflections, going forward I have made a conscientious effort to be present with my patients in all aspects when given the opportunity. I recently completed a pediatrics hematology/oncology rotation where I met a young man who was 18 years old and admitted for a sickle cell pain crisis. I got to know him well during the course of his hospitalization including his hobbies and interests, and we bonded over our mutual love of basketball. On my overnight shift while we were playing NBA 2k, I had the realization that soon enough there will be a time where I won’t be able to have these types of relationships with my patients. As long and intense as residency training is, we as trainees are gifted with the time to be available and present for our patients. Similarly, being there for patients and family members during end-of-life care is a unique experience to take part of. Back to my MICU reflections as an intern, there were many times that families weren’t allowed in the intensive care unit when patients were dying from COVID. As bedside providers, we served as conduits for family members that could only be virtually present with their loved ones. Back then I didn’t appreciate the responsibility and privilege I had serving in that role, but thankfully time and experience has taught me how special it truly was.

It’s an interesting feeling having recently completed a four-year residency program and now starting fresh again in a sports medicine fellowship. I will miss the middle of the night camaraderie that comes from the team-oriented approach when responding to critical situations in the hospital. The bond you establish in residency with your co-residents, including those across other specialties, is something that I will never undermine or discredit.

Thanks to the pandemic, my “new normal” of my everyday workflow includes the sensation of joy and appreciation during that split second prior to knocking onto my patient’s room. I enjoy laughing with children at their well child checks and comforting others when delivering bad news because I am present. I am thankful for the opportunity to learn from all my patients and will forever be grateful for the experiences that my Med-Peds residency training has taught me.
The Perspective

Phil Jurasinski, PGY-3
University of Missouri–Kansas City, Missouri

Med-Peds

They created me with alchemy—
one part pediatrician—one part internist—
Almost the ultimate generalist—
Though we don’t do obstetrics or surgery.

I am there for the infant and the elder—
I care for the privileged and those without shelter—
Though I will be twice boarded, the only credential
I need is to believe in human potential
And the spirit we should all put on the differential.

I have a heart of gold but my neurons are lead-heavy—
With knowledge condensed from two ethereal fields of study—
And I appear when the medical field is unclear—
To bring crystal focus when transition care grows muddy.

Sometimes my peers call me a chimera—
A relic of the LBJ 1960s era—
Undecided on the potential of what I may be—
Instead of a New England Robert Frost poem
With two roads diverging as he had wrote them—
I travel both to the forest glade of my destiny.

If medicine is vermillion red and pediatrics sunshine yellow—
The orange my blood mixes paints the autumn leaves—
And so shall I be a physician for all ages and stages—
That is what it means to be med-peds.
Claudia Heritage, MS4
SUNY Upstate Medical University, New York

**Learning to Cope: The Emotional Toll of Medicine**

My very first rotation of third year was Internal Medicine. During my first week, I was rotating at the local VA and our team was on long call, meaning we also carried the responsibility of being the code team. After morning rounds, the pager went off. The team quickly made our way to the room for which the code was called and lying on the hospital bed was a cachectic 60-something year old man with a puddle of blood on the floor and blood oozing from his mouth with each compression the RN was giving. The resident on my team handed me gloves and whispered, "Be ready, they might need someone to take over compressions." I stood there, transfixed by the scene unfolding in front of me. It wasn’t my first code blue experience as I had been a patient care assistant prior to medical school and performed CPR on multiple patients, but this was the bloodiest code I had ever seen. I listened as a resident read out the pertinent history, and the attending asked for specific orders to be placed. Eventually, after multiple interventions with no return of circulation, time of death was called, and just like that, we returned to our team room to finish up our daily tasks.

Twelve weeks later, after a busy psychiatry evening call shift, the resident I had worked with the night prior tracked me down. He didn’t want me to find out another way and told me the patient we had seen in the ED the previous night and had subsequently discharged, had gone home and killed himself with a gun. I was stunned. I had seen the patient not even 12 hours ago, where he had told us that he wasn’t suicidal, had no plan, and didn’t have any firearms in his home. I was searching my brain for what we had missed and had a deep ache in my gut. The patient was a 65-year-old veteran who had a history of major depression but was at the hospital seeking respite care on the psychiatry floor. He expressed no overt suicidal ideation, but just felt like he needed to get away from his life stressors. After careful evaluation, the resident spoke with the attending, and with there being no available beds on the unit and the patient was not in a crisis, the decision was made to discharge him home.

On my OB/GYN rotation, I had the ability to assist in family planning procedures within the hospital. I was grateful that my education included this learning experience. As someone who fully supports a woman’s right to choose, I was not expecting to feel mixed emotions about the procedures I watched and assisted with. But my heart felt heavy, and I felt that distinctive lump in my throat after I watched the first fetus go through the vacuum aspirator.

The first time I saw a baby die was during a call shift with a pediatrician in rural Upstate NY. An Amish family sought care for their new baby, Isaac, because he was dusky and not breathing. We worked on Isaac for over 7 hours, but our interventions failed. I had spent three hours manually bagging, but we ultimately extubated him. I wanted to say something meaningful to the family, but anything I could think to say sounded so miniscule. So, I sat there...
in silence while in my head I counted off each breath to give. Once we compassionately extubated Isaac, I was ready to go home after an exhausting day.

What's missing from the above stories is what happened after all these mentally and emotionally taxing experiences, and how I learned to cope.

After the code blue, the resident on my team sat me and the other students down to debrief what we had witnessed. We went over the medicine side of things, but more importantly how we were feeling emotionally after witnessing someone die. We each took turns sharing how we felt and what support we needed to get through the rest of the day. This was a powerful experience for me as no one had ever asked me how I was feeling after a code. Even when I was a patient care assistant performing compressions, we just went back to the normal routine of our job after the code, burying the emotions to get through the rest of the shift.

After the resident told me about the patient who committed suicide, we spent a while talking with each other and reflecting on our conversations with the patient. The resident validated my feelings of disbelief and guilt that we hadn’t done more and that because of our inaction, the patient was now dead. After I reflected on the experience more, I realized the resident had likely tracked me down to share what had happened to also check in for themselves. Together, we shared how we were feeling and were able to support each other in that moment as it was something that we both experienced.

Prior to being involved in the family planning procedures, the resident I was working with pulled me aside before starting to make sure that I was okay participating. She told me that if I was uncomfortable, she could place me with another surgical team that day and that I shouldn’t feel pressured to be involved. She also counseled me that at any point during the day, I could excuse myself and that she was available to talk about any feelings I had or questions about the procedures. She made herself available that day and any day after to have open conversations. I appreciated her attention to ensuring my emotional wellbeing and together we shared how being involved in the procedures made us feel.

After witnessing Isaac die, I was extremely upset. I’ve always thought of kids as resilient as they can get better so quickly and for the most part they are healthy. However, this case challenged my world view. As I was bagging Isaac, I felt my eyes welling up watching the family hold him while we waited for the paperwork to be finalized for them to leave. I was so focused on the medicine that my emotions hadn’t caught up to me yet. I didn’t want to seem unprofessional, so I tried to dissociate. Once behind closed doors with my attending is when I finally let my guard down and my emotions flowed. My attending was so supportive and together, we cried for Isaac and talked about how we were feeling.

I was lucky that in all these situations there was someone there who wanted to support me and validate my feelings. In medicine, there is often the tendency to dissociate from the feelings as it can be seen as unprofessional. Over time, many physicians become numb to the
emotional toll of medicine as a coping mechanism. But I think it is important to have our feelings and to not lose the humanistic and empathetic aspects of being a physician. I hope to one day be a supportive resident and attending to those training below me, to my peers, and to my colleagues. I want to teach others that it is okay to have feelings in medicine and help them discover coping strategies to handle difficult experiences. Together, we can change the culture of medicine and put a little emotion back into practice.
Jerome Watts, MS4
Howard University College of Medicine, Washington D.C.

"There's no place like home."
- The Wizard of Oz by L. Frank Baum

I loved the opportunity to aid the children and families, especially when they are faced with situations that encroach on a patient’s ability to just be a kid. For instance, Little Messi (my nickname for him) – a tiny three-year-old boy – and I were able to hang out every Saturday for a couple weeks.

Often, his nurse would find us laughing in the hallway as I pushed him around in his little taxi with his IV and monitor in tow. When he was exhausted from having new lines put in, I would roll the taxi by his room, making sure to give a “honk” of the horn so he knew that his ride had arrived and was ready to go if he was.

It is moments like this that really showed me that while the hospital is often no place like home, it can be anything that children and their families want and need it to be for their well-being and comfort. With some care and imagination, a patient room can turn into a magical fort or a gallery filled with masterpieces, or a toy car can transform into a usually prompt and fun taxicab service – leaving space and time for parents and families to decompress.

It is essential that the hospital always be a place where patients and families know and feel that they will be safe and cared for. Regardless of the situation, children will be children; however, it is on all of us – healthcare providers/staff, medical trainees, and volunteers – to help make their visit one of healthy wonder, even if it isn’t home.
Joanna George, MS2
Oklahoma State University Center for Health Sciences, Oklahoma

I see her everywhere in my first year of medical school: the hands of our body donor in anatomy lab, the dangerously high lab values in a test question, the case studies that always begin with a deceptively simple complaint. When most people think of a physician’s touch, they flinch instinctively at the thought of probing fingers, disrobing in sterile examination rooms and answering uncomfortable questions. But I soften wistfully at the memory of gentle hands untangling my knotted wild hair, the scent of onions caramelizing on a warm kitchen stove, the familiar weight lying beside me until I fell asleep at night. Before I understood that my grandmother was a physician, I knew her as the essence of “hospes,” the root word for hospital: shelter, refuge, and safety.

She calls me inside. I’ve been climbing barefoot again. She can’t fathom why I’d choose not to wear shoes. Her softly-chiding voice is like bare feet against bare earth, anchoring me deeply in place. Stability: it’s a gift I don’t notice until the ground shifts.

The first time she is disoriented, I carefully curl up beside her on an ambulance stretcher and hold her hand. Her shoulders are hunched tightly with fear, but relax against my touch. When the emergency room nurse arrives, I stand gingerly on the cold hospital tile to answer her questions. I wish I knew where my shoes were.

Memories of her catch me off-guard as I sit in our lecture hall. We’re learning about paroxysmal nocturnal dyspnea - and suddenly, I’m kneeling on the worn carpet in her bedroom, watching her struggle to breathe. It’s 3:47 a.m. and her choking panicked cries have woken me up again. I rush to position her upright, desperately rubbing her back in circles as she hunches forward to gasp for breath. My professors have taught me the name for this process but she brought their words to life. I check her oxygen saturation, readjust her nasal cannula, and wonder absently if this is why some physicians rely so heavily on metrics. It is easier to distract myself with this routine than to helplessly watch the fear in her eyes. Unexpectedly, she slowly smiles at me. Caring for me through her simple reassurance, even as I desperately fumble to take care of her. I can hardly bear to look at her but I cannot bear to look away. Our lecture continues, and I struggle to return to the present moment. I love pathology but I’d trade my newfound knowledge for another glimpse of that smile.

I fiddle with the diaphragm of her stethoscope when we learn basic clinical skills, speculating about her own experience. How long did it take until she felt confident listening to someone’s heart? I try to imagine her long before she ever became responsible for putting her rambunctious grandchild to bed; a lifetime before the same grandchild learned how to bathe her gently before bedtime. I close my eyes tighter but all I can picture is my own hands pressed to the inside of her wrist, her neck, her chest, holding my breath as I checked
frantically for hers. I shake my head at the wide-eyed nurse aide fidgeting apprehensively across the room, unsure how to exhale after I’d finally confirmed that she’d stopped breathing.

I review her medical records from the weeks before her death, skimming quickly and almost hungrily with complete disregard for clinical relevance. I am not searching for disease; I am searching for her. Someday, as a physician, I will be expected to look for potential in these charts: to note signs of what is unfolding or what to do next. But for now, I am not interested in “what”, only “whom”. Hoping for a new detail which reminds me of who she was, a lingering memento of her personhood pressed like a flower between progress notes and imaging studies.

The phrase that strikes me most deeply is in the first line, before her medical history or chief complaint: “a pleasant woman”. Pleasant. I repeat it to myself, taking comfort in this tiny word. I wonder about the notes that my grandmother must have taken as a physician. I suspect that there is more of her there - in what she noticed, believed, and recorded - than in her own medical chart. What would I write if I was forced to summarize my long encounter into this abbreviated format? Curious, I skip over her review of systems and conduct my own.

I close my eyes and begin at the top of her body, as we were taught. She is no longer here for me to “appreciate” her heart murmurs or palpate her baby-soft skin. Instead, I formulate my list of pertinent positives and negatives from memory. The smell of floral shampoo that I massaged into her soft hair, pressing lightly over her temples to relieve her mild headaches. The tremor in her hands as I helped her hold a spoon, pausing between mouthfuls so she wouldn’t aspirate. The sound of the whispered words she spoke over me as I fell asleep, before she was sick…the same words that I sang softly to her before bedtime as I tucked her in…and again, one last time, as I carefully washed her lifeless body and covered her with a folded white sheet. When I’m finished, my list reveals more than what was taken from her through illness- her privacy, her mobility, her independence- and highlights everything that she gave me in return.

Is it possible to record life this way? During my next standardized patient (SP) encounter, my SP winks when I ask about her exercise levels. “Does running from my problems count?”, she quips laughingly. Afterwards, we only have nine minutes to document the most pressingly relevant parts of our encounter. I recall the clinician who paused to recognize my grandmother as pleasant, and included her calm, kind demeanor alongside her test results and symptoms. Remembering my SP’s jokes and vivacity for life, I uncap my pen and write:

“Pt is a vibrant 73 y/o woman.”

Vibrant. It’s just one little adjective before her age and gender; a reminder to both of us of the personhood beneath her disease.
**The Perspective**  

Brenden Garrett, MS4  
UT Southwestern Medical School, Texas

**Well, That Was Nice of You**

“Hi, this is general surgery. Confirmed with my team that Mr. S will not go for biopsy today. Better shot tomorrow. NPO at midnight would be great, thanks!”

This was the message I received as I was leaving the hospital. It was the end of a long day after a long week on IM wards, and I was ready to go home. But this message seemed to have other plans for me. Mr. S had been NPO since midnight awaiting a lymph node biopsy to workup an infection in the setting of HIV, and this biopsy would be an important step in diagnosing his condition. It was now after 6pm, and he had been fasting for at least 18 hours. I was not about to let him continue fasting until maybe getting the biopsy at an unspecified time the next day, so I walked back to my workroom to put in the orders.

I pended the order to get him a diet, coordinated with the patient’s nurse to call the cafeteria to get him a meal, and then asked a resident to sign the diet order. He was a bit confused as to why I was giving the patient a diet and then returning him to NPO at midnight, so I explained the situation. When he understood the lengths I had gone through to get the patient a dinner, he said with a bit of confusion on his face, “well, that was nice of you”. I heard his unspoken message, “I’m not sure this was worth your time”.

As I’ve reflected on this experience, it had never crossed my mind to not go back to make sure the patient would get a meal before continuing fasting. Sure, I could have saved some time and effort by just going home and letting the patient continue NPO until he got the procedure. But as far as I could ascertain, the patient had no indication for a 36-hour fast, and leaving him hungry for a day-and-a-half just to save myself work did not seem like a reasonable option. Personally, if my mom (or another loved one) were in the hospital and was left without food for 36 hours just because it would be more work to change her orders, I would be furious. After this experience, I was left thinking about what “high-value care” means to me. I think being efficient, saving money, and managing time well are all important. But in medicine, I think that compassion and kindness are just as important. Indeed, in the patient’s eyes, these may be the most important factors. I hope the field of medicine can resist being reduced to transactions, and instead remain a sacred space for nurturing, healing, and alleviating suffering. I don’t think it is “nice of you” to stop a patient’s unnecessary NPO orders; I think it is nonmaleficence in action, stopping the healthcare system from causing harm to the patient. Even when it means going out of our way, I hope we can all keep the patient’s needs in the forefront of our minds, and treat each other with the respect and compassion that we all deserve as human beings.
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