



H&P

The Stanford Medical Student Journal
Volume 14 | Number 2 | Fall 2010

STORYTELLING

EDITORS-IN-CHIEF
Andrew Chang
Ryan Schubert

ASSOCIATE EDITORS
Clinical Case Reports
Ryan Schubert

Humanities
Katherine Bell

Global Health
Karen Yan

Leaders in Medicine
Andrew Chang

LAYOUT
Stesha Doku

EDITORIAL GUIDANCE
Andrew Connolly, MD, PhD,
Associate Professor of Pathology

Audrey Shafer, MD,
Professor of Anesthesiology

Abraham Verghese MD, MACP,
Senior Associate Chair for the Theory and
Practice of Medicine

FRONT/REAR ARTWORK:
Front Cover photo by Stesha Doku.

Back Cover photo "Life in the Hands"
by Agnieszka Czechowicz.

GRAPHIC REDESIGN
Stesha Doku: dohkoo.com

POLICY

H&P, the Stanford Medical Student Journal, is published by students of the Stanford University School of Medicine. All articles are written by students. H&P is not an official publication of the Stanford University School of Medicine or its faculty. Expressed written opinions are solely those of the authors and do not necessarily represent those of Stanford University or the School of Medicine.

SUBMISSIONS

H&P is published quarterly. Submissions are accepted by e-mail.

Please submit inquiries to StanfordHPJournal@gmail.com. Correspondence may be addressed to OSA, Stanford University School of Medicine, Stanford, CA 94305.

<http://bioethics.stanford.edu/arts/H&P.html>

LETTER FROM THE EDITORS

Dear Readers,

Thank you for taking the time to read the latest issue of the H&P. This edition of our journal is entitled "Medical Storytelling", in tribute to the thousands of stories medical students will hear during their journeys as healers. Though listening to patients' tales may seem like a crucial aspect of being a physician, far too often do students lose sight of this vital human aspect while engrossed in interpreting lab results and procedural outcomes. The patient narrative is dismissed as solely a means of gathering information. In hopes that we can inspire our peers to consider the bigger picture, we present this theme.

You may also notice a stylistic shift in our publication. H&P is excited to welcome back Stesha Doku (SMSIII) and her leadership in our layout department. Proving that Stanford medical students are not only intelligent, but also extremely creative and talented, Stesha has put her artistic expertise into redesigning the magazine.

In addition to the compelling power of the patient narrative, we were interested in exploring the accounts of both medical students and residents. As such, Elsie Gyang (SMSIV) contributes a wonderful piece composed of snapshots of last year's graduating class and their road to residency positions. This is particularly timely, as our own Class of 2011 embarks upon their residency application trails this term.

Next, Rebecca Hjorten (SMSV) explores the possibility of a hidden tale in her piece "Tragedy". Her experiences in the OR with a special case showed her that a patient's story can also be found in their body, and reminds us all of the awesome humanness of our profession. To continue our humanities section, Alexa Bisinger's

(SMSV) poem "Morning Sounds" presents the parallels found in our lives—both in the clinic and outside—while Casey Means' (SMSI) poem "Phacoemulsification" elegantly relates the story of a cataract surgery.

This issue also has a special photoessay by Dr. Phouc Van Le, graduate of Stanford Medical School. Dr. Le recently had the opportunity to provide emergency relief with Dr. Paul Farmer's Partners in Health following the Haiti earthquake. He offers H&P a unique look at how the medical community has responded to the terrible tragedy.

Our Global Health article for "Medical Storytelling" was provided by Mihir Gupta (SMSI) who reports on India's National AIDS Control Plan (NACP). NACP has taken a new approach to fighting AIDS, one that takes into account patient stories in determining the best course of action for HIV patients. Mihir also exposes the unfortunate effects of disease stigma with a patient interview, an example of how rumor and misconception can marginalize those most in need of help.

As in all our issues, we conclude the H&P with a faculty spotlight, Leaders in Medicine. Amalia Londono Tobon's (SMSI) interview with Dr. Peter Pompei, a geriatrician and educator, illuminates a faculty member's perspective on patient storytelling. As a physician with great experience dealing with the narratives of an aging population, Dr. Pompei's words of wisdom are true gems.

From the staff of H&P, we hope you enjoy the issue. May you encounter many wonderful and moving stories in your own medical adventures.

Best,

ANDREW CHANG AND RYAN SCHUBERT

Features

4 Stories From The Road To Residency

ELSIE GYANG

Humanities

8 Tragedy

REBECCA HJORTEN

Humanities

10 Morning Sounds

ALEXA D. BISINGER



Phouc Van Le

Humanities

11 Haiti: A Photoessay

PHOUC VAN LE

Humanities

17 Phacoemulsification

CASEY MEANS

Humanities

18 Photography



Stesha Doku

Global Health

25 A Story to Remember

MIHIR GUPTA

Leaders In Medicine

29 Leaders In Medicine Dr. Peter Pompei

AMALIA LONDONO TOBON

STORIES FROM THE ROAD TO RESIDENCY

ELSIE GYANG



Stesha Doku

1

TO IOWA WE GO!

CLAD IN A RED WISCONSIN SWEATSHIRT, jeans and a pair of tan fuzzy gloves, Gabriel Martinez-Diaz grins from ear to ear as he poses in front of the orange and black Smart Car he drove from Chicago to Iowa. As if the miniature car wasn't tiny enough, at 6'5", Mr. Martinez-Diaz, who goes by the nickname Gabi, towers over the car in the photo, later laughing as he recounts the details of his almost 4 hour drive maneuvering between much larger cars and trucks. "I almost died!" he exclaims, laughing boisterously.

But the trip, however anxiety-inducing, was worth it. Gabi made it on time to his residency interview at the University of Iowa's Department of Dermatology, joining the ranks of other hopeful medical students eager to attain one of four coveted first-year residency positions. Given his background - a male, Puerto Rico-born Latino-American with a larger than life personality to boot, Gabi doesn't meet many people like himself on his interview trail. For a moment, Gabi takes a serious tone when talking about his interest in dermatology. "Providing and improving access to specialty care is a passion of mine, particularly in regards to pediatric dermatology, where seeing a dermatologist can take as long as 6-9 months." When peering into his future, Gabi envisions a career in dermatology that involves community medicine, providing care to underserved populations through working at free clinics, similar to the ones at Stanford.

For now, Gabi folds himself as he climbs back into his rented miniature vehicle. He's headed back to Chicago where he will continue his interview tour around America. He pauses for a second and notices that it's starting to snow, which in Iowa may signal the beginnings of a blizzard. He's a bit worried, to say the least. &

DECISIONS, DECISIONS...

2

FAMILY MEDICINE? PEDS? FAMILY MEDICINE? PEDS?

By the beginning of her fourth year Melissa Morelos still could not decide which specialty to go into, so she applied to both.

Ms. Morelos grew up in what she describes as a low income, primarily Latino community that had a lot of needs, especially in terms of health and education. Having fallen in love with science and medicine, she knew at a young age she wanted to serve her community as a physician.



Shubha Bhat

In her formative years Melissa faced many decisions – whether to use drugs, join a gang, or drop out of school – that could have veered her off track. But with a fiercely supportive family, Melissa made it to Stanford as an undergraduate and medical student. This is one of the reasons why Melissa loves pediatrics. “There is a lot of potential in kids. You don’t know how they’re going to turn out and they have a lot of opportunity to change. I like seeing potential and guiding it where I think it should go.”

Even so, Melissa believes she can have just as big of an impact in her community as a family medicine physician. “I like that family medicine is focused on the whole life cycle, birth to death, and you can be involved in some aspect.” She also loves how family medicine practitioners approach patient care. “They don’t just care about your medical problems, but also your social problems. They’ll try to help you with anything else you need, even look up a bus schedule with you to help you get to appointments.”

By the end of her interviews, Melissa finally made a decision and will only be ranking one specialty when she submits her rank order list, due at the end of February each year. “If you’re between two fields, do a continuity clinic,” she recommends. Offered through the Family Medicine Department, FAMMED 310A allows students to work with a faculty preceptor and their preceptor’s patients in a medical specialty of a student’s choice for one afternoon a week for 9 months. “It’s well worth it because it’s the rest of your life!” she laughs. &

ON APRIL 28, 2009, 100 miles south of San Francisco, a tour bus carrying 36 passengers overturned on an overpass of Highway 101. Five died, many others were injured.

Seven patients were airlifted to hospitals in the Bay Area, two of whom were brought to Stanford Medical Center. Philippa Soskin was working in the Emergency Department as part of her Surgical ICU rotation when she witnessed resuscitation efforts for one patient who was said to have been ejected 60 feet from the tour bus onto the other side of the overpass.

Soskin recalls, “It was amazing to see the trauma and ED teams save her life in the acute setting, and then to see ICU staff care for her until she was discharged four weeks later to the floor.” After weeks of intensive care, Philippa’s patient finally made it back to her home country of France, alive and well.

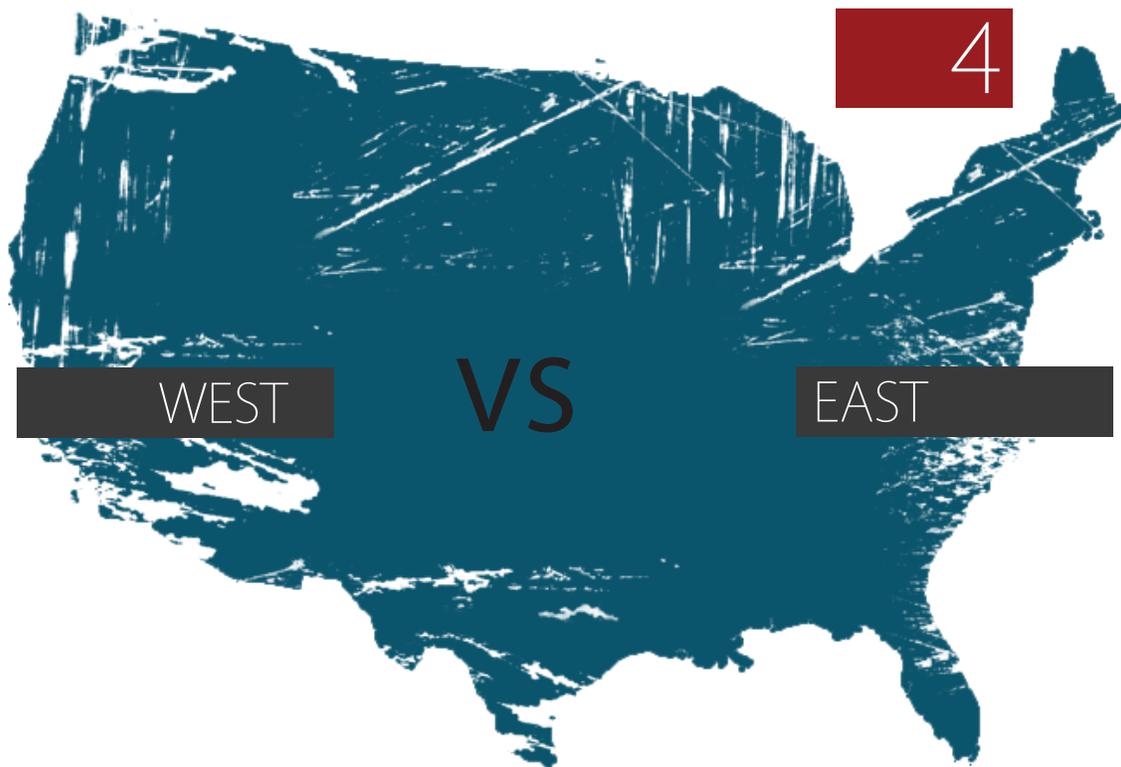
Philippa matched in Emergency Medicine last Spring.

Ms. Soskin, a Champaign, Illinois native, always had an inkling that she would pursue a career as a physician after a successful ER shadowing experience in college. Nonetheless, Philippa decided to take the scenic route to medical school. During her college career at the University of Illinois she discovered an equally compelling interest – health policy. After graduation, she leapt off to Tanzania to volunteer in public health education and nonprofit management. She returned after a year to study Public Policy at the John F. Kennedy School of Government at Harvard University. Eventually, though, Ms. Soskin began to miss patient interaction and the science of medicine.

Though she vacillated between surgery and emergency medicine, Philippa reasoned that because of its schedule and multifaceted nature, emergency medicine would allow her to continue to enjoy her passions in medicine, international and domestic health policy research, and travel.

Reflecting on her clinical experience, Philippa offers the following advice – “learn a little bit about the different specialties early on, especially subspecialties that you won’t get much exposure to in clinics.” And try things that you think you might not like. You never know! &

LARRY OZOWARA LOOKED UNEASY as he recounted the story of a resident who claimed that East coast Attendings were so malignant that she heard of Attendings inflicting cigarette burns on



residents who answered questions incorrectly! A myth? Let us all hope so. Nevertheless it was surprising to find that a year and a half after telling this story, Mr. Ozowara was fearless in applying to and interviewing at a number of East coast psychiatry programs. “I liked a lot of programs on the East, actually” the California native from Rancho Cucamonga admits.

Even so, I wondered if Larry, who is more jovial than intense, more smiles than scowls, would really enjoy the oft described “cut-throat” nature of East coast residencies. “I like to work hard,” he asserts, and whether he goes East or stays West he’s ready to do whatever it takes to become a great psychiatrist.

His work at Stanford speaks to his impeccable work ethic. As an undergraduate Mr. Ozowara was a founding member on Stanford’s Division I wrestling team. He earned a Masters degree from the Department of Psychology at Stanford, a department consistently ranked #1 on U.S. News and World Reports. At the medical school he excelled as a pre-clinical and clinical student and worked on research concerning the ethics of particular psychiatric

practices. Not to mention, he’s quite the multi-tasker, reviewing lecture notes and clinical cases while working out at the gym religiously.

At a Psychiatry residency panel one student asks Larry whether it is possible for someone to know *a priori* if they’ll end up preferring a relatively large or small residency program. “Just apply broadly,” Larry suggests. “And after each interview write down what you liked and didn’t like about each program. That way you can get a sense of what kinds of programs you’d like to see yourself at in the end.” When asked if he knows where he’d like to see himself, Larry laughs, “I don’t know yet!” &



TRAGEDY

REBECCA HJORTEN

FOR THE PAST MONTH AND A HALF

I have been carrying around this phone. Meticulously checking for missed calls. Seeing if it is on vibrate or ring. Placing it in on the sink while I shower so I know I will hear it.

When I received the call, the surgeon on the other end of the line asked me if I could be in front of the ER in 30 minutes. I rushed to the hospital. As I sat waiting outside the ER, nursing a small cup of coffee, I tried to fathom the range of emotions our patient was feeling. At that very moment, this exhausted person was learning that their life had just changed forever. A liver from a

matched donor had just been found. The transplant team had been assembled, and the surgery was definitely going to happen, and in less than a few hours. On that day, my life changed too. I was elected part of the transplant team. I was about to help harvest an organ.

We were soon swooped away in a dark SUV with tinted windows to a small private jet. Sitting in the plane I felt like there was something surreal or sexy about the whole experience. Like I was a character in a movie, waiting by the phone for a mysterious phone call that could come anytime, day or night, signaling that it was time to be whisked away by plane to an undisclosed location.

However, my romantic movie fantasy ended when I got gowned, gloved and sterilized, watching the surgeons split a sixteen year old boy's body from collarbone to pubis, cracking open his sternum to reveal the anatomy underneath. This was reality, the reality of a sixteen year old boy who had been driving his first car, for the first time. And for just a second, a barely perceptible moment in time, as his story was relayed to the team readying themselves to empty him of his organs, it was as if the entire room gave an inaudible gasp, emptying the air from the room and leaving a silent, still vacuum.

And then there was motion, as the entire room moved in harmony, the surgeons anxiously watching the clock, walking the line between speed and precision to preserve each of the critical parts of the young body before them. Removing the chest wall, everything below was revealed. Having spent hours bent over a cadaver, carefully dissecting each vital anatomical structure, I had no idea how different this would be. But there before me, for the first time, was human anatomy alive and vibrant with colors. As opposed to the still, cold, pale grey of the cadavers, the structures were shining, translucent, and moving to the beat of the heart. The heart was perched in the center of the chest, seemingly

bursting out of his body, pulsating rhythmically. As I held the small intestine out of the way as the surgeons cross clamped various structures, I could feel it beating in my hands. It was beautiful.

“And for just a second, a barely perceptible moment in time, as his story was relayed to the team readying themselves to empty him of his organs, it was as if the entire room gave an inaudible” gasp, emptying the air from the room and leaving a silent, still vacuum.”

And in this room, in the silence between the surgeons, in the glances from the nurses, I could feel the patient and his story just sitting there. In that moment, surgery felt like those times when you are on the highway...perhaps stuck in traffic...and you are afforded the opportunity to look into other people's cars...intimate glimpses into their lives. They are doing what you do: talking on the phone, looking in the mirror, playing with their kids. A single moment in the grand arc of their lives.

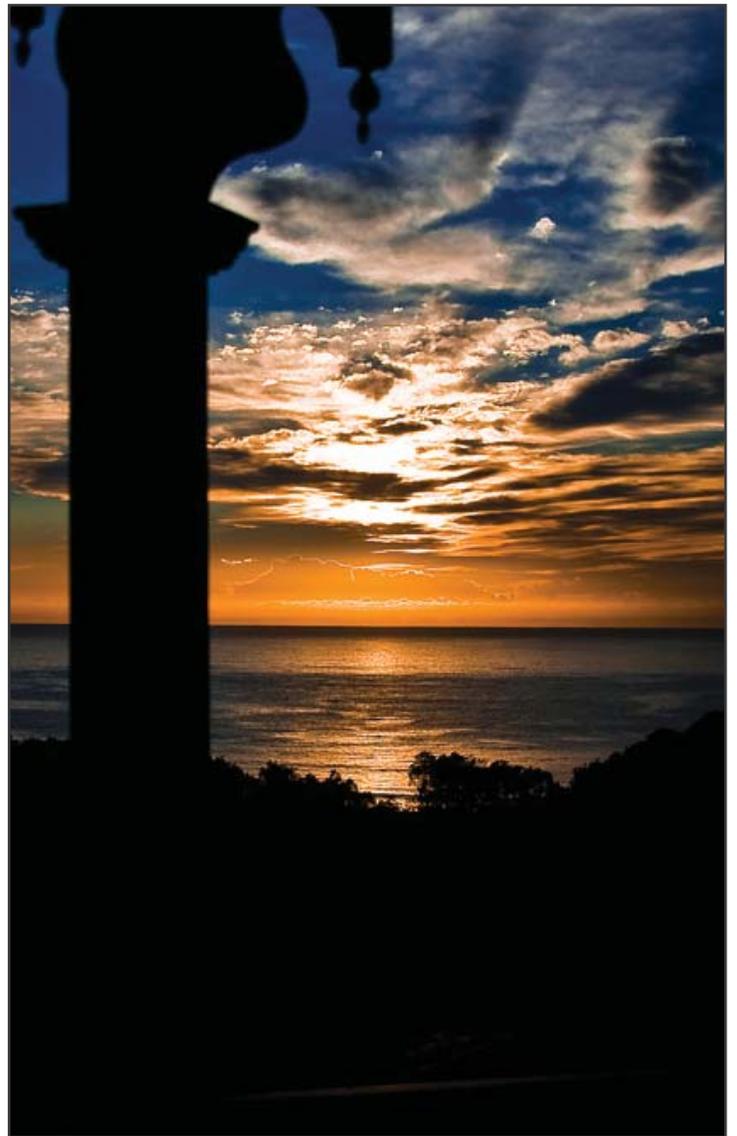
And in this surgery, we were witnessing a singular moment in someone's life. Glancing off of a tragedy, and there was an awareness: this patient could be you, it could be your mother...it could be your child. Standing in the operating room, there was a sense of reverence for the moment, an appreciation for being able to be a part of it—by allowing us to be a part of his death, sharing his beautiful, translucent anatomy, he was giving the gift of life. &

MORNING SOUNDS

ALEXA D. BISINGER

In the morning
In the hospital I hear
The pulsox alarm
(10 more minutes)
The heart monitor go off
(It's ready)
And someone yell "Clear"
(It's done)
Mourning.

In the morning
I am at home and I hear
The alarm go off
(10 more minutes)
The dishwasher sound
(It's done)
the coffeemaker beep
(It's ready)
I get out of bed
Starting a new day



Stesha Doku

HAITI

A PHOTOESSAY

PHOUC VAN LE



Above:
Collapsed National Palace

Right:
Patients at University Hospital





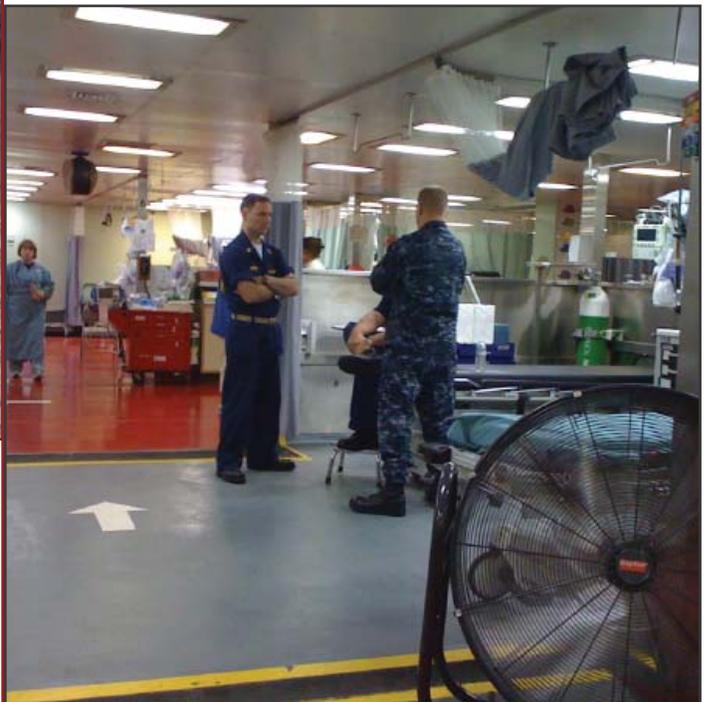
Left:
Transferring an intubated one year-old from Port-Au-Prince to the US (The patient recovered fully)

Below:
Sunday religious procession



Above:
Transferring twin babies from the USNS Comfort to the PIH NICU in Cange, rural Haiti

Right:
in the triage area of the USNS Comfort (hospital capacity 1000 beds)





Above:
Transferring patients by helicopter

Below:
With PIH local employees (Joseph Clerveaux and Saul Cesar)





Left:
With two other residents, Natasha Archer and Ranu Dhillon

Below:
in the 20 bed ICU tent at HUEH



Above:
Transferring patients by helicopter

Right:
Dr. Phuoc Nguyen, right, with Dr. Paul Farmer (founder of Partners in Health and Deputy UN Envoy to Haiti) aboard the USNS Comfort to visit patients





Above:
The USNS Comfort

Below:
One of the dozens of groups of medical volunteers from the US doing 1-2 week clinical trips





Left:
Soldiers lowering a PIH patient to board a helicopter to the USNS Comfort

Below:
Destroyed church in Port-Au-Prince



Above:
View of destruction in Haiti

Right:
The flooded PIH volunteer base camp



PHACOEMULSIFICATION*

CASEY MEANS

I must tell you
 this round eye
 whose incised and glistening cornea
 lets sticky

clear fluid seep
 (steel rod
 probes careful) oozily
 slipping down firm white

sclera
 where blood appears from
 tiny desperate vessels as
 scalpel tears

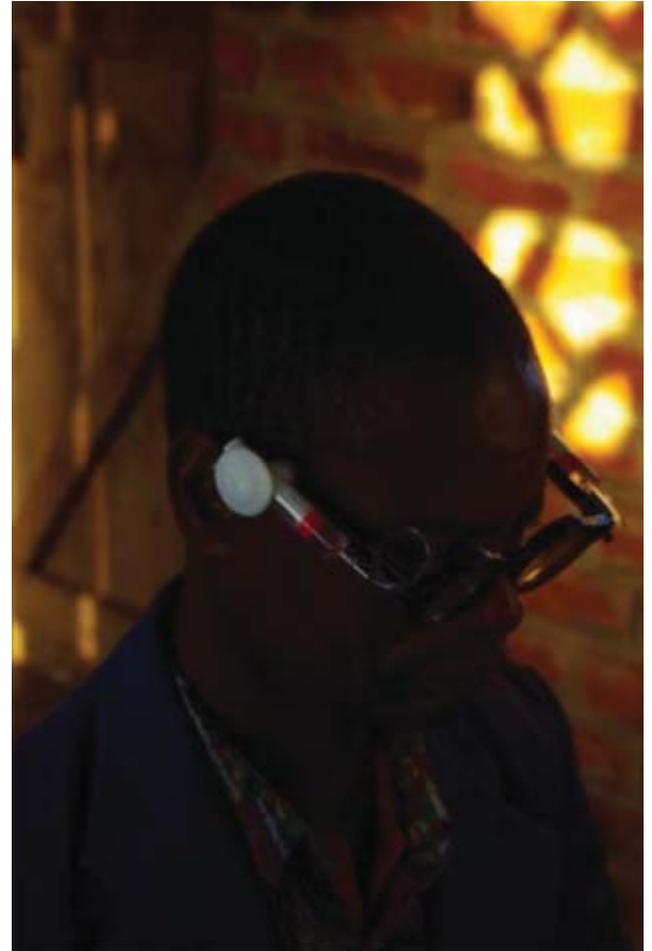
further the flesh,
 fibrous and soft, this
 small globe
 ruptured to be healed so

it lets the syringe push the cut
 wider
 and a flooding of
 salt water fills the chamber

aggressively
 as the lens is made to shake until
 it shatters
 to pieces that float in thick fluid,

dissolved completely but one
 last spurt of saline
 abruptly, and out
 of the cut they come

together:
 needle, fragments,
 blindness and blade.
 New lens, quick stitch, and sight

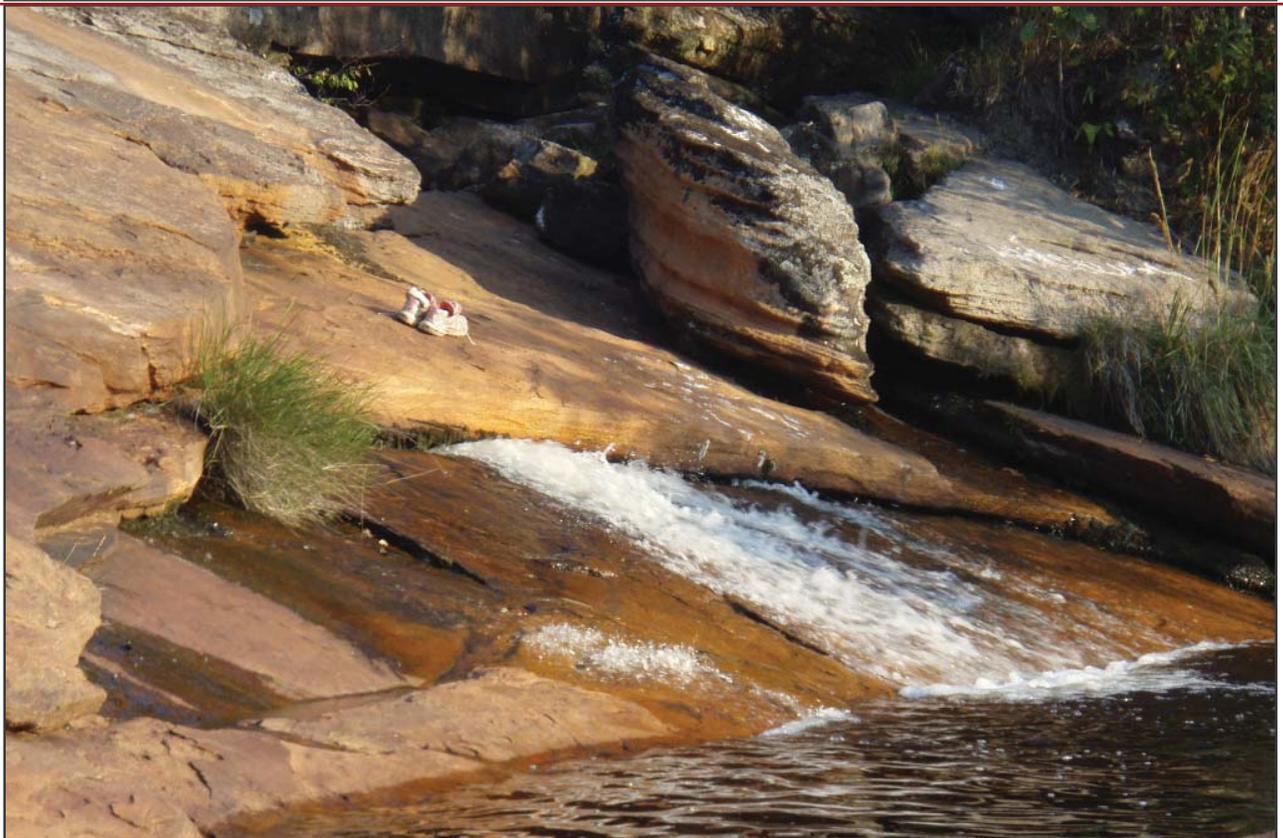


Emilia DeMarchis

*Note on Phacoemulsification: A form of cataract surgery during which the eye's internal lens is dissolved into small pieces using an ultrasonic frequency emitted from a rod that is inserted into the eye through a small incision. Dissolved lens and eye fluids are pushed out of the eye using liquid pressure and replaced with an irrigation of salt solution. A plastic lens is inserted, and the eye is stitched shut.

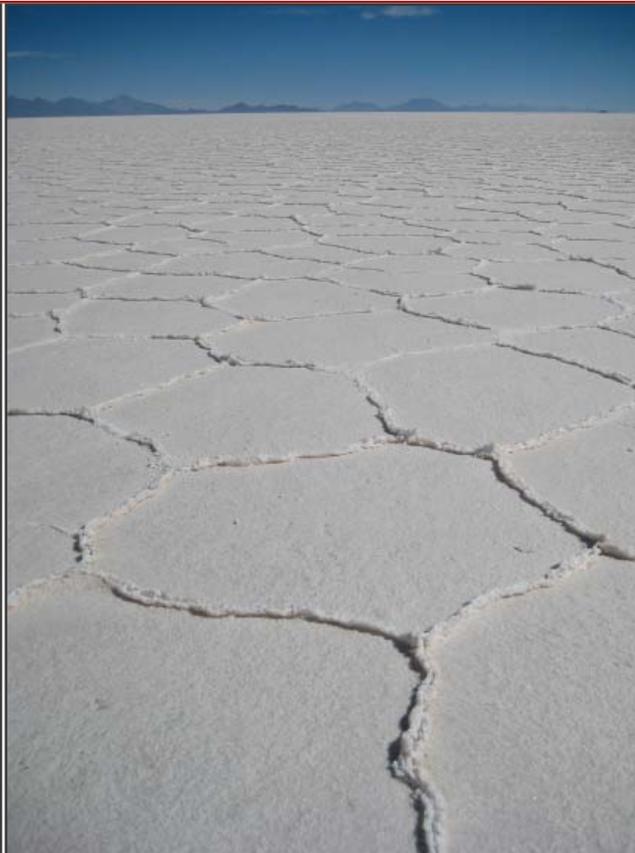
photos by
MIKE SUNDBERG













photos by
MALAVIKA PRABHU



ONE STORY TO REMEMBER



“THEY SAID THAT I CAUSED HIS DEATH

– that I was unfaithful while he was away in the city. They told me I deserved to get HIV, and my children did too. They chased us from the village. The clinic out there told me I had five years left if I got treatment. Back then, what hurt the most was the cost. I knew I would suffer, even if it was his fault, but our savings were supposed to be for the children’s food.”

The examining room fell silent as Sanjana paused to adjust her *saari*, a vibrant green against a backdrop of concrete gray and dull brick ochre. Not one to delay, even in the pressing heat of a midsummer afternoon in northeastern India, she continued. “We moved a lot, relying on my

MIHIR GUPTA

India’s Response to the AIDS Epidemic

All photos by Mihir Gupta

All names in this article have been changed in order to protect the privacy of the patients and individuals discussed in this article.

relatives until they found out what I had.” Sanjana gestured towards the social worker’s office. “It looked pretty hopeless until Priti found me.”

Priti, the social worker, had also been both widowed and infected by HIV/AIDS. Her husband, like Sanjana’s, sought work in large cities like New Delhi because he could no longer support his family on the dwindling rural supply of arable land. During the months away from their families, their husbands engaged in behavior that infected them with what they called *mahamaari*, ‘the great killer.’ They had little knowledge that they were at risk, much less how to limit their exposure. Unfortunately, their wives and children suffered the consequences.

Sanjana’s experience reflects many of the underlying themes in the socio-medical history of HIV/AIDS and healthcare in general – namely, the profound influence of poverty, culture, education, stigma and gender inequity on health. Even after she contracted HIV, Sanjana’s fate, it seemed, would be decided by her town’s rumors and a clinic’s verdict.

Luckily, both the town and the clinicians were wrong. With antiretroviral therapy (ART), Sanjana could expect to live far beyond five years. Moreover, Priti helped Sanjana realize that she would not have to choose between ART and feeding her children. In fact, she could receive both her medications and a monthly food allowance for free. This sudden windfall came from the Indian government’s National AIDS Control Plan (NACP), which had expanded to the states of northern

India in 2007, one year before I met Sanjana. During that year, Sanjana integrated herself into a network of women who shared her story. Some of them were from the same village, and had even stigmatized her before finding that they too shared Sanjana’s fate. The network was so large that it spawned multiple smaller support groups – Sanjana called hers “my new village, in the middle of the big city.”



The NACP initiatives that aid women like Sanjana were pioneered in India’s southern states, where the HIV/AIDS epidemic hit early and hard. The architects of the NACP had the key insight that fighting HIV/AIDS in a populous, extremely diverse country like India required an equally numerous and diverse set of

actors from the public, private and non-profit sectors. The resulting infrastructure was an alphabet soup of agencies, programs and policies for connecting members of high-risk groups to resources under the NACP umbrella. A key component of the NACP was to provide competitive, merit-based funding for non-governmental actors to pursue outreach in known high-risk populations, namely commercial sex workers, men who have sex with men, and injecting drug users.

Of course, neither Sanjana nor her husband belonged to any of these populations. The 2007 incarnation of the NACP identified them as ‘migrant



workers,' a new, high-risk group. The fact that the outreach infrastructure, built practically overnight in the northeastern states, even found Sanjana is a testament to its extreme responsiveness and mobility. Initially, however, the architects of NACP did not anticipate the need for a system to find individuals who moved rapidly between the country's remote interior and its bustling metropolises. The original plan was to create strong but static resources – large centers providing HIV/AIDS testing, counseling and therapy – with, at least theoretically, wide catchment radii. When this had no effect on the incidence of HIV infection, policymakers switched to the more decentralized, targeted approach in practice today.

Sanjana was a direct beneficiary of that change. The diverse patchwork of small, locally based agencies that helped her included an NACP-funded rural women's NGO where she met Priti, a local HIV and tuberculosis testing center, a private fund that provided her transportation to a city hospital, and a support group that helped her find work. All told, Sanjana worked with four different NGOs and two public hospitals spread across an area spanning 1200 square miles. Even with her extraordinary resilience, this journey would not have been possible without a previously static

system adapting to the mobile nature of HIV/AIDS in contemporary India.

Furthermore, NACP was a successful program because it was responsive to the failures of its initial urban-centered model. Its strategy of surveying individual experiences and identifying the unique situation of migrant workers helped it tremendously. For example, resources were initially targeted to major cities based on geographical rates of incidence and prevalence. But only when NGOs on the ground started interviewing HIV-positive individuals did they realize the numbers in cities were artificially high. Indeed, the large migrant worker populations who actually lived in rural areas were spreading the virus outside the cities where they were being monitored.

Facing an increasingly large population of HIV-positive migrant workers, stakeholders created networks to provide a common base of support but also the conditions for individuality to flourish—for women like Sanjana to navigate their own way through myriad agencies, but to also connect with those who shared their experiences. This approach has also



been successful with high-risk groups in urban areas; NGOs stationed everywhere from alleyways to railway stations build rapport with local residents and launch screening efforts to find new pockets of infection before it is too late. Evidence suggests that this paradigm pulled India back from the brink of an HIV/AIDS pandemic. According to the World Health Organization, prevalence actually declined from 0.45 percent in 2002 to 0.29 percent by the end of 2008.

It is important to remember that the progressive NACP approach relies not just on listening to the individual stories behind HIV infection but also on challenging the competing narratives that tell HIV-infected individuals that they are guilty, hopeless and untouchable. Indeed, communities stigmatizing their own members can be as pernicious as the socioeconomic inequities that drive HIV infection in the first

place. Outreach systems must present alternatives to these stories and institutionalize the counter-narratives through meaningful infrastructure.

As lucky as Sanjana has been, she remains HIV-positive and may not live to see her daughter finish high school. Someone with her fortitude and grace might not be in that situation but for her gender, class, and rural origins. And even India's low prevalence amounts to almost three million HIV-positive individuals, each with their own story, and each story governed by its own themes. Sanjana keenly reminded me of that fact as she gathered her *saari* and left the examining room. "I know you'll hear a lot more stories," she said, "but try to remember mine." &



LEADERS IN MEDICINE

DR. PETER POMPEI

AMALIA LONDONO TOBON



Dr. Peter Pompei, M.D., F.A.C.P. is an Associate Professor of Medicine at Stanford University and is active as a teacher in the Medical School, the Internal Medicine Residency and the Geriatric Medicine Fellowship. He has been honored with many teaching awards and the American Geriatrics Society Geriatrics Recognition Award. Dr. Pompei completed his undergraduate degree at Johns Hopkins, his medical degree at the University of Chicago, his residency in internal medicine at the University of North Carolina and his fellowship at Cornell University. He is board certified in Internal Medicine and Geriatric Medicine and is a Certified Medical Director.

Q: Dr. Pompei, would you please introduce yourself?

I was born in Chicago, spent most of my life in the Midwest and East Coast, then finally came to Stanford 17 years ago. I work here in internal medicine, geriatrics, and medical education.

Q: What made you choose medicine and geriatrics?

When I was in medical school, I thought I wanted to do internal medicine. When I did my first rotation in general surgery, however, I became interested in surgery and went on to pursue two years of residency training in general surgery. I ended up returning to my first love, though, and completed a residency in internal medicine. My focus in internal medicine has always been generalism, and so I did a fellowship in general internal medicine with a focus on clinical epidemiology. When I looked for my first faculty job, the new head of General Internal Medicine at the University of Chicago—Christine Cassel—asked me if I would join her group and change my direction from general medicine to geriatrics. So that’s how I got involved in geriatrics: it wasn’t a long-standing passion of mine, although it is true that much of our work in internal medicine is caring for older people because they carry the burden of illness in our society.

Q: Where does your passion for medicine come from?

My passion comes from really getting to know individuals and from working with them over time in addressing their medical conditions. Someone once described geriatrics as “supra” specialty as opposed to a subspecialty,

in the sense that geriatricians need to pay a lot of attention to things outside of what many would consider a traditional doctor's role. We have to be aware of healthcare financing issues, social services, and community resources that patients can benefit from in their ongoing healthcare management. There is also a need to interact with families, because older people have committed family members who participate in their care.

Q: What are the rewards and challenges of caring for the elderly?

Let me start with the rewards. The continuing relationships I have with patients is what is most sustaining in my professional life. The privilege of caring for patients over time, seeing them in different settings, and continuing to care for them with whatever health problem they develop is sustaining and rewarding.

As for the challenges, I think some have to do with the system of health care in this country. Much of this is because what would make people's lives much better, or at least easier, may not be available because of insurance and other financial constraints. Even access to specialty colleagues can be constrained by insurance issues; this is a reality of current practice.

Q: Relationships with patients are very important to you. This issue is focused on medical storytelling. Broadly, what does storytelling mean to you and your practice?

There are several aspects of story telling that I find engaging. I am intrigued, excited, and sustained by the stories that patients tell me. I always presume that each patient has a story to tell and I do whatever I can to allow them to

share it with me. Stories can take many forms: what they are worried about, what they are interested in, sometimes about their families or friends. There is also the story of their illness and trying to understand fully what the illness means for and to them, what the ongoing management is for them, coping with illness,



coping with disabilities, functional decline, etc. The other side of storytelling is sharing that story with students, residents and fellows and being able to present the information that the patients have shared with me in an engaging and compelling way to provide the best care for patients.

One thing that I like to point out to students or residents is that I often start by exploring the patients' personal and social history. Beginning there has several advantages: one is to develop rapport,

but especially for my work as a geriatrician, because of the high prevalence of cognitive problems and dementing illnesses in the patients that I see, it allows me to assess aspects of their memory. Patients with cognitive impairments are more frequently able to remember things from the distant past, but as you progress to the more recent events, there can be a drop in their ability to recall details. This gives me a very important clue early on that there may be cognitive problems that I will need to attend to, no matter what their presenting symptom might be.

Q: Could you share with us a story you have heard in your time as a physician?

A patient came to see me who had very ad-

vanced lung cancer from which recovery was unlikely. Despite the poor prognosis, she wanted to be very aggressive about her treatments. This was frustrating to some, it seemed futile and wasteful. We spent some time talking to her and exploring her situation, and it turned out that she had a disabled son in his 40s living in a Board and Care facility. This really changed the whole picture for everyone because we realized that what was important for her was to stay alive as long as possible to support her son. She was worried that when she was gone, her child would have no advocate or family support.

Those are the kinds of stories that I think are important. Her disease and its treatment was only a small part of a bigger picture of care and devotion to her son. It is important for us to understand the whole picture in order to provide her the best care possible.

Q: Thank you for your insights. To change the subject, what are your interests outside of medicine?

I do have a strong interest in languages and cultures around the world, something I've been interested in from a very early age.

Q: Could you tell us more about your early interest in languages?

My grandparents on my father's side were both immigrants. My grandfather came from Italy and my grandmother from Poland. Every time we visited them, it was like entering a completely different world. They had different cultural traditions, enjoyed different foods, and spoke languages that I didn't understand very well. That experience got me started. When I got to high school, I was selected to be an exchange student and spent a year in France living with a family and attending secondary school near Paris. I later studied Russian and Portuguese. I traveled to the Republic of Ireland with some friends, where I encountered Gaelic. In the Caribbean, I was fascinated by Creole, and later on a trip

to West Africa I began to explore Arabic and tribal languages. Living in New York, Chicago, and California, I've been working with Asian populations, and I am also interested in Mandarin and other Chinese dialects.

Q: Where did your passion to work with medical students come from and how did it develop?

Many years ago when I first went to college, my aspiration was to become a high school mathematics teacher. I have had a long-standing interest in the educational process and have been fascinated observing teachers: watching how they engage students, transmit information, and spread knowledge. Now in Medicine, my interests have shifted towards promoting the next generation of physicians.

Q: Do you have any advice for medical students?

I'd like to encourage students to find their own passion. Find what is sustaining for you in terms of daily activities and work-life balance. This is going to be different for different people, and it's a little bit challenging in medical school. After all, you don't get a full picture, only a glimpse into what it will be like in a particular specialty field. But you can begin the quest and learn from the faculty and your colleagues about the many opportunities our fields have to offer.

Don't be surprised if there are some false starts. I would view my two years of surgery as a false start, but I don't have any regrets; without exploring the surgery, I would not have known for sure whether or not it was a good fit. When things do not work out, there are always other opportunities. One of the most amazing aspects of the profession of Medicine is the many career paths it offers. 



H&P