VOICES

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Inside this issue...

"Stories, we all have stories. Nature does not tell stories, we do. We find ourselves in them, make ourselves in them, choose ourselves in them. If we are the stories we tell ourselves, we had better choose them well."

-James Orbinski, former president of Doctors Without Borders

I started medical school yesterday. All things considered, it was a pretty ordinary event. I sat in an auditorium from 8:30 to 4, covering material that was mostly review from the prerequisite courses for med school. Though I will say that there is an odd feeling to wearing a white coat inside a hospital for the first time.

Today was a little different. Throughout the year, we will occasionally have patients come in with their doctors, and they'll both talk with us about their experience treating and dealing with a particular disease. It's a good introduction to healthcare, from the inside and outside. Today, our guest was a 13-year-old boy, who came in with his family and entire medical team to talk about his experience with Ewing's sarcoma – a cancer of the bone.

While trying to refrain from overstating, I have to say it was a powerful presentation. The patient had intense pain for almost a year before he was diagnosed, went onto chemo for months, then got the news that he had successfully beat the cancer at the age of 12. To summarize his telling of the story, he told us in a thoughtful and genuine fashion: "It wasn't so bad. I mean, there were parts where everything hurt, and I had to miss school, and I really didn't like that , and

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sometimes it hurt a LOT... but I just told myself that I had really nice people with me, and that it wasn't that bad... and it wasn't. You just have to have a good personality."

Keeping in mind... this is a story about having **cancer.** I think that's quite the philosophy.

So after everyone – family, doctor, nurse, NP – talked about their experiences with the disease (with a lot of justified praise for the patient), it opened up for questions from the students. Quick note about the structural awkwardness of this arrangement: there is a group of about 7 people at the front of an auditorium, facing about 100 coat-wearing medical students. That image probably says enough. Yet our guests were willing to make themselves completely vulnerable, offering themselves to answer any question we could come up with. At one point, a student asked the family about how they got the news of the boy's diagnosis and what they thought about it. Not an easy question. The mother starts to tell the story... but breaks down part way through, unable to finish.

I get an unfiltered feeling of complete *awfulness*, for seeing the mother have to relive what must have been one of the most difficult moments of her life, in front of 100 strangers. But at the same time... part of me, underneath the awfulness, wants to know the story, to know what made it worse so that I can avoid doing that one day. Just as I disgustedly realize I'm thinking that, the dad takes the microphone and finishes the story. And I feel... I don't know. Grateful?

...Or maybe lucky? The doctor who spent the most time with everyone involved said that he felt this family was a perfect example of why he knew he should be in medicine. He said that it was a privilege to participate in the stories of the people and families he sees, to be let into other's lives and to learn from them. And I believe him without the slightest doubt. I also saw this 13 year old boy put his hand on his mom's shoulder to comfort her when she broke down during her story, and couldn't help but think "Man, they're right, this kid really is special." I was taking pride in this boy that I had only known – using the term loosely – for less than 2 hours. And I was doing so because despite the formal, forced setting, this family was letting me in on their story.

So stories have been on my mind today. I've kept thinking about Orbinski's quote, which is one of my favorites...

> *"Stories, we all have stories. Nature does not tell stories, we do. We find ourselves in them, make ourselves in them, choose ourselves in them. If we are the stories we tell ourselves, we had better choose them well."*

I found myself in a story today, and I was lucky to have that chance. Much more noteworthy, however, was the young boy telling the story, and the self he chose by saying: "It wasn't so bad." He chose well, for everyone in that story.

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Sickness in Malawi

Did you know…

Nerve impulses to and from the brain travel as fast as 170 miles per hour.

The brain operates on the same amount of power as 10-watt light bulb.

The human brain cell can hold 5 times as much information as the Encyclopedia Britannica.

http://icantseeyou.typepad.com/my_weblog/2008/02/100-very-cool-f.html

Ayub's wife cooks the best food I have found in all of Malawi and I had taken to absconding from the school to their house for lunch. On one such afternoon I was basking in the afterglow of a huge Afghani meal when I began to feel a dull ache in my gut. I passed it off as the result of overstuffing my shrunken stomach, but later that night the pain returned. After dinner I laid down on the bed and began massaging my abdomen and complaining to Jes who was taking her customary pre-bed shower.

"When did it start?" She yelled over the shower water.

"This afternoon at Ayub's… I think it's just gas though." There was a pause in the conversation as Jes rinsed her hair.

"Where does it hurt?" I moved to the left side of the bed so that I was visible through the open bathroom door.

"Right here," I said, jabbing a finger in my lower right abdomen.

"Huh, weird," said Jes, as she turned off the water and began toweling off. I went back to massaging my abdomen for several minutes until Jes walked by on her way to the kitchen and said in an offhand way, "isn't that where your appendix is?" My heart did one of those sudden big lub-dubs that is followed normalcy and a feeling of anxiety flowing from your heart to your extremities. I had actually already noticed that the pain coincided with my appendix but somehow having another person make the same observation added to the credibility. The pain was pretty minor though, and I convinced myself that it would probably subside by morning. It didn't.

My medical options were slim; I could get the problem looked at locally or go to one of the private hospitals in Blantyre (the largest city in the country). When Jes had gone to Koche, the local clinic up the road, the young man examining her had proudly announced that he was going to be taking his MSCEs soon. The MSCEs are high school performance exams, so Koche was obviously not a good option. The Mangochi District hospital was a little bigger and a little farther away but also did not have much to recommend it. Mangochi District Hospital serves 50,000 people and has three doctors. An American medical student who worked there once recalled to me that he had seen ants crawling inside an IV tube attached to a person. I had heard good things about the hospitals in Blantyre, but they were a 5 hour bus ride away, a journey not to be taken lightly.

I woke up Sunday morning and the pain was worse. I tried to tell myself that it was worse because I had spent the last week pushing and prodding my abdomen, but the time for rationalization was quickly passing. It was at this moment that I realized how nominal my 'health insurance' really was. Jes and I had both purchased catastrophic travel insurance before we left the States. The policy, aside from having a high deductible, was pretty

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good. It would airlift you out in case of emergency and would pay up to two million dollars. Yet before you can be flown out of country you need to find a plane, that means Blantyre or Lilongwe. Both cities are hours away on bad roads and I sincerely doubt a leer jet is standing by. As comforting as those travel insurance plans feel, I suspect Jes and I were, and are, at the mercy of local medicine in nearly all emergency scenarios. As I faced the prospect of acute appendicitis, my options were really no greater than a well to do Malawian. Since the local clinics were closed on Sunday, I waited.

Monday morning came and the pain was worse. As I went to the breakfast table I felt my abdomen jarred by pain from the movement of walking. Jes joked that it was probably because I was so heavy footed, but her teasing manor couldn't mask the nervous edge in her voice. I didn't feel like eating so I drank a protein shake while Jes picked at some bread and mangoes. Sibale (a local friend) arrived at 8am to take me to a local doctor. I stepped gingerly into the front car seat and bade farewell to Jes.

The 30 minute drive to the clinic was mostly paved but bumpy dirt patches caused me to rise off the seat in a vain attempt to shield my abdomen from the rough road. We left the car in a dirt parking lot and walked the final hundred feet. Several men were sprawled out on the front steps and every available seat and patch of floor was occupied by sick looking people. I was ushered over to the check-in desk where the attendant promptly asked to see my health book. A health book is a small notebook the size of index card used for medical records. It has things like your weight, age, sex, and notes from past clinic visits. Fifty cents later and I was the proud owner of a Malawian health book. I was then ushered over to a line of chairs against the back wall which lead to a closed door.

After several minutes of waiting someone came out of the door. Immediately, every other person in line shifted to the next seat with amazing speed, considering most were probably sick. I was reading at the time and kind of missed the cue so was leapfrogged by the woman behind me. 'Oh well, I'll get it next time,' I thought.

After five or six more seat changes I was the one entering the examination room. I was pretty thrilled; the queue had only taken about a half hour. Inside, there were two women, a small bed, a scale, and an old-school blood pressure machine. I immediately realized this was not the doctor's office, just the nurse screening. I was weighed, had my blood pressure taken, and was then ushered to the next, longer, line of chairs. To my relief, the door at the end of this line read, "doctor's office." Forty minutes later and I was face to face with a doctor with just enough gray hairs to exude a reassuring confidence. The doctor asked me some questions and examined my abdomen, all the while without making eye contact. "Well," he said, "I think you have acute appendicitis." He started writing in my health book. Reading his scrawl upside down I saw the entry: refer to Mangochi District Hospital for management.

"So you think I should go to Mangochi District Hospital?" I asked. He looked up, a bit startled that I had been reading his notes.

"Mangochi is where we refer appendicitis cases," he said in a voice that sounded like he used this line frequently.

"So they can treat appendicitis at the district hospital?"

"Well, it where we refer patients for appendicitis."

"I heard that," I said, "but would you recommend going there?" He stopped writing momentarily and fixed me with a gaze that for the first time suggested he was pulling out of automaton mode.

"Well, if you need surgery you may want to go to Blantyre," he said.

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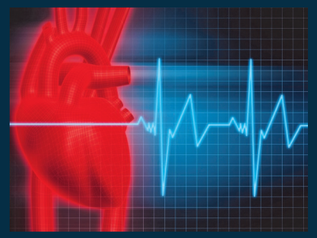
Did you know…

The human heart creates enough pressure to squirt blood 30 feet.

The human body is estimated to have 60,000 miles of blood vessels.

Women's hearts beat faster than men's.



http://icantseeyou.typepad.com/my_weblog/2008/02/100-very-cool-f.html

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"Do you think I will need surgery?"

"In my experience most appendicitis cases are surgical." He paused again, and then said in a rather frank voice, "You should go to Blantyre."

Within minutes I was on the phone with Jes. "We're going to Blantyre," I shouted into the phone as the SUV bounced along the bumpy road. Jes had spent the morning wrangling transport and had serendipitously been connected with Octavio. Octavio is the former ambassador of Portugal and I had spoken with him on several occasions as he often stays at his lakeshore chalet near MCV. He happened to be returning to Blantyre with his wife and, upon hearing about my medical predicament, had moved up his departure time.

Jes and I had decided upon the 7th Day Adventist hospital which came with good reviews from everyone we talked to. After proving that we had adequate financial resources (in my case, being white was enough), I was ushered back to a waiting room that was so cold I was shivering within minutes.

My doctor was a young and very nice Chinese man with an American accent. He became excited upon hearing that I was here volunteering for the year. "That's how I started out in Malawi too," he said, and then with a sheepish look added," and I never left."

After a bit of poking and prodding he said, "I am going to admit you and call the surgeon for a consult, it does present like appendicitis." The doctor seemed worried about my condition and before I left the examination room the surgeon had been called and was on his way. I was promptly put in a wheelchair and wheeled to the ward, a trip that actually involved going outside and down an alley.

As I was taken down a barren but very clean hallway I couldn't help but feel as if I was in the 50's. Nurses (all female) walked up and down the corridors wearing white dress uniforms with little white hats. My room was painted white and was barren except for a curtain and an old-style iron frame bed. Behind the curtain was my roommate, an older and well-off Malawian man.

The surgeon also poked and prodded me and after asking several questions said, "I don't think this is appendicitis; wrong place, wrong symptoms. It could be an infected caecum. We will give you IV antibiotics tonight and if it doesn't get better we will operate tomorrow." The surgeon left and I picked up a book and prepared for a long night in the hospital.

A small placard on the wall said, "Visiting hours strictly enforced. Patients will be billed for unauthorized visitors present outside of visiting hours." The approved visitation times were very short and I thought the stipulation seemed rather strict. The rules at the Adventist hospital also seemed at odds with the attitude of my doctor, who had encouraged Jes to stay with me, even through the night. The rationale behind the visitation rules became clear when, at 5:30 pm, the hospital was besieged by an army of visitors. The halls were suddenly filled with a mass of talking bustling people darting in and out of rooms. My roommate had about 30 visitors crowded around his bed. Visitors entered the room single file dressed in their Sunday best. They all spoke with my roommate briefly,

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then relegated themselves to the far side of the bed and stood in respectful silence while others took their turn. Visitors entered in phases, and although there were never fewer than 20 people in the room, it was obvious the different visitors belonged to different parts of my roommate's life. Some groups interacted with the intimacy and familiarity of family, while other groups were clearly professional associates. Many visitors, upon noticing my glaring lack of company, came over to talk to me. It was quite nice to have someone to talk to and I ended up meeting the author of the biology textbook Jes uses in her class.

After the half hour visitation period had passed I gained a full appreciation for the strict rules enforced by the hospital. I have come to the opinion that everyone and their uncle, their neighbor, and their distant cousin visits hospitals in Malawi. Seeing the positive effects these visits had on my roommate really made a strong case, in my mind, that we need to step it up in the old USA. The visitors even improved my mood since my roommate, in true Malawi style, shared his extra visitors with me.

My first night in the hospital (or any hospital for that matter) strangely reminded me of trying to sleep on a long airplane flight. People kept waking me every 3 hours to take my blood pressure and refilled my IV. Jes, feeling guilty about sleeping in my bed in the presence of sisters (all the nurses are nuns), had been sleeping on the cement floor but after several hours her fortitude was overcome with weariness. The nurse, upon entering the room to find Jes in my bed, made a comment along the lines of: "what took you so long." Morning came slowly but was punctuated by another half hour of visitation when my roommate once again entertained dozens of guests.

I spent the following day in the hospital on an emotional rollercoaster as my abdominal pain fluctuated from better to worse to better. By the end of the day the pain was a bit better and the surgeon decided that my problem was actually a partial intestinal block which should pass with hydration. I was pretty stir-crazy by this point so was very in favor of being discharged. The surgeon agreed that I was probably safe to leave but recommended I stay close by until the symptoms completely disappeared.

I am feeling completely better now and am back in Mangochi. The experience made me appreciate how accessible quality medical care is in the United States. I was in one of the best hospitals in Malawi and there were no CAT-scans, no MRIs, and I suspect, few specialists. There was a poster on the wall advertising the visitation of a neurosurgeon to Blantyre. Apparently, a neurosurgeon from South Africa spends part of his year visiting, for several days each, seven sub-Saharan African countries. The poster listed the dates he would be in each country and stressed he was only doing consults. While this neurosurgeon is shared by seven countries, my home town of 50,000 people has two neurosurgeons to itself. The level of care available in Malawi, even at the best institutions, is limited. Imagine having access to care only as sophisticated as a community clinic in the United States. How would your life be different if your health was constrained by these limitations? Such is life in Malawi.

Written by Jesse Fitzpatrick MSIII in 2009, when he was living in Malawi Africa Teaching high school science at the Malawi Children's Village

Drawing by Jing Han, MS1

Selected Excerpts from Gregory's 1st Moleskin S.F.

10/2

Jen just came home and told me she kissed Jason the MSIII last night. She is staying at her parents' tonight, per her suggestion. I called Tobias and he told me not to be rash, man, told me to talk it through with her, bro, not to lose her, dude. Somewhere in that conversation there must have been poignant insight, but emotion clouds judgment, as if my full glass of clear, purified water has been carpet-bombed by Alka-seltzer tablets. What the fuck?

Dad told me not to confront Jason since I'm still an MSI, but instead to just wait three days, then talk it over with Jen. Mom wants me to blow her off until she comes crawling back. A test of devotion, she said. I don't know what I want to do, but the exam isn't for two weeks.

10/3

Cons:
You're a vegetarian.
You're an Ortho gunner.
You hate spicy food.
Your dad hates me.
Your sister flirts with me.
You're obsessed with Justin Bieber.
You say you don't want kids.
Your mother is a terrible cook.
You're afraid to ride the subway.
You're unwilling to pay for cabs.
You hate James Bond.
You prefer Merlot.
You're a lousy cook.
You own multiple vibrators. And named them after deceased Presidents.
You won't kiss me when I'm stubbly.
You're a compulsive shopper.
You were a Barney kid.
You hate the Ninja Turtles.
You laugh when I order salads.
You cringe when I order beans.
You like to fuck to Polka.
You take too long of showers.
You give me sass when my text responses are late.
You treat my weed stash like a Whole Foods cheese display.
You always 'accidentally' forget my items on the shopping list.
Your felatio teeth:tongue ratio is way off.
You left the oven on. Overnight. Twice.
You only initiate 10% of all kisses.
You thought Conan O'Brien was a baseball player.
You don't say the second 'a' in caramel.
You think extra cheese is a pizza topping.
You think Perez Hilton counts as news.

You still talk about Jason.

10/4

Pros:
We both like Nutella on our toast.
You're not a psychiatry gunner.
We both like extra butter on our popcorn.
Your dad is loaded.
Your sister flirts with me.
We both love a good dance party.
You are way more decisive than I am, I think.
You give the most amazing head massages.
You are incredibly organized.
We both have incredible libidos.
You ask me questions about my day.
You sincerely take interest in my thoughts.
We both love to ski.
You make me laugh.
I make you laugh.
You'd rather drink rye than wine.
My parents love you.
You give me all the olives in your Greek salad.
You always make the coffee in the morning.
You took care of me when I broke my femur.
You think it's cute when I stare at other girls.
My friends think you're awesome.
You don't mind when I piss on the seat.
I'm not upset when I wake up next to you.
You smell like Taco Bell. I love Taco Bell. You're always honest with me.
We both love flossing.
Your teeth are naturally bleach-white.
We both love to people watch.
We both love Q-tips.
We both love the post-coitus-cuddle.
We both love Portuguese water dogs.

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10/5

I came home from studying at Penultimate Cup and saw that Jen had called. No message. I didn't call back. I ran to the hospital to visit my dean and I ran into Jason. It was his mistake, he said, but I gave him a shiner anyways. He said he deserved it. We pounded fists.

10/6

I got plastered with Jason last night and woke up face down on my couch, shoes dangling from my toes. Jen left a message for me saying that she'd give me as long as I needed to talk to her, that she had spoken with Jason, that I knew where to find her. I rolled a joint and brought it to the park. I got high and watched people pass me by.

10/7

Jen was waiting for me at Penultimate Cup. We got caffeinated. We made up. Ish.

10/16

Standard deviation below the mean on my Anatomy test. P=MD, unless you're Jen, who only got one question wrong that she said was actually written incorrectly anyways.

10/17

We got a Porty and named it Golgi.

Finding the Country Doctor in an Urban Jungle: An American Medical Student's Experience with Home-Based Medical Care in Singapore

A Brief History of Home-Based Medical Care in the United States

Home-based medical care in the United States has a long and complicated history. The origins of American home care date back to colonial times, when medical house calls were the norm. Doctors were more or less self-sufficient, able to perform simple diagnostic tests and prescribe medications autonomously. Reimbursement for these services was also simpler in those days. Today we would call it a fee-for-service model, but in the colonial era, the fee was agreed upon privately by doctor and patient, not dictated by hospitals, insurance companies, or the government [1]. While the romanticized notion of the "country doctor" may sound like the ideal way to administer medical services, a house call-only approach to healthcare could not keep pace with the rapidly advancing medical technologies which emerged in the post-WWII era. Cutting edge diagnostic and therapeutic equipment required greater storage space and regularly-scheduled, skilled maintenance. Meanwhile, widespread, low cost means of personal transportation enabled patients to travel to healthcare centers. The growth of hospitals allowed physicians to specialize and provide more focused care. Healthcare consumers raised their expectations in light of technologic advances, , and thus hospitals and clinics became the primary venues for the exchange of healthcare services.

The popularity of house calls in the United States, which accounted for 40% of physician encounters in 1930, plummeted to 10% in 1950 and less than 1% in 1980 [1].

After 1980, the story of home-based medical care in the United States has been closely linked to Medicare, the federal health insurance program for seniors and those with disabilities and end-stage renal disease. Medicare provides home healthcare services to its beneficiaries. Before 1980, these services were limited to recently-hospitalized patients, but in the 1980's this requirement was abolished. Additionally, Medicare began to grant home healthcare coverage to previously denied patients with chronic diseases and lost its authority to override physician's orders for home healthcare without providing explicit evidence that this care would not benefit the recipient. As a result, utilization of Medicare home healthcare services increased, until studies published in 1996 suggested that these services were over-utilized and failed to reduce hospitalization and length of stay [2]. Shortly after the publication of these data, Congress passed the Balanced Budget Act (BBA) of 1997, which reduced utilization of these services by over a fifth [3, 4]. The BBA hit certain home healthcare recipients harder than others, especially those over 85, women, minorities, and patients with certain diagnoses [4]. *(continued on page 10)*

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Nevertheless, home healthcare is experiencing a resurgence in the United States. In 1998, Medicare revised its billing codes to increase physician reimbursement for house calls by 50%. Three years later, a similar increase in compensation was offered for physician visits to assisted-living facilities. As a result, American physicians made over 2.5 million house calls in 2010, compared to just 1.5 million in 1995. This expansion of home-based medical care seems likely to increase. The recently passed Patient Protection and Affordable Care Act (PPACA) of 2010 contains the Independence at Home (IAH) Act, which will provide home healthcare visits to the most medically complicated and high-cost Medicare beneficiaries and coordinate their care by establishing a team of physicians and nurse practitioners available around the clock [1].

The boom in American home healthcare has not been confined to government-run programs such as Medicare or the extensive federal Veterans Affairs (VA) Hospital-Based Home Care program. Private academic medical centers, hospitals, and primary care practices are getting in on the action. As in the early days of home healthcare, these entities operate on a largely fee-for-service basis. However, they often receive payment from insurance firms such as Medicare, although some private groups, termed concierge practices, cater to wealthier, non-Medicare patients only. Whereas the mass-availability of automobiles once contributed to the decline of home medical visits by enabling patients to travel to more central hospitals and clinics, private practices are now employing large vans equipped with sophisticated diagnostic tools to provide on-the-spot, cost-effective lab results to their home-bound patients. The state of home-based medical care in the United States has truly come full-circle, with advances in healthcare delivery beginning to catch up to America's cutting-edge medical technology [1].

Home-Based Medical Care in Singapore

Singapore's history of home-based healthcare may not be as lengthy as that of the United States, but Singapore's healthcare system draws on the traditions of Great Britain, where physicians make 10 times as many house calls per year as American physicians, and 100 times as many house calls to patients greater than 85 years of age [1]. Not surprisingly, home healthcare is readily available in Singapore. Home healthcare provides services to homebound patients, defined as those for whom "leaving the home will require considerable and taxing effort due to a condition that limits [their] mobility" [5]. Those who qualify have access to professional medical and nursing care as well as skilled volunteer services. All eligible patients undergo means testing, whereby they are placed into 4 categories based on the level of government subsidization they will receive: 75%, 50%, 25%, and 0%. The management entities for Singaporean home healthcare services are known as Volunteer Welfare Organizations (VWOs) and rely heavily on public donations in addition to government funding [5]. The monthly cost of home healthcare ranges from S$300-600 per month [5], comparable to the roughly S$300-500 per month cost of a nursing home [6].

An American Medical Student's Experience with Home-Based Medical Care in Singapore

As an American medical student conducting research in Singapore for the better part of a year, I had the privilege of participating in over 30 home healthcare visits. During my first clinical year in America, I never encountered such an opportunity. American medical education centers around inpatient hospital wards and the operating room (or operating theater, as they call it in Singapore). Outpatient exposure is limited to high-volume primary care clinics, much like Singapore's polyclinics, or specialist clinics. Certain educational institutions, such as Harvard Medical School and my own Duke University School of Medicine,

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Did you know…

On any given day, sexual intercourse takes place 120 million times on earth.

The largest cell in the human body is the female egg and the smallest is the male sperm.

The three things pregnant women dream most of during their first trimester are frogs, worms and potted plants.

http://icantseeyou.typepad.com/my_weblog/2008/02/100-very-cool-f.html

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offer an alternative clinical track focused on longitudinal care. However, I opted for the more traditional route, and I never would have known how limited this approach was if I had not taken part in home medical visits in Singapore.

Shortly after arriving in Singapore, I began accompanying the Home-Based Intermediate Care (HBIC) Service, a division of the Family Medicine and Continuing Care (FMCC) Department at Singapore General Hospital (SGH). The department graciously allowed me to join them on home visits to patients discharged from the hospital in the previous six months. The HBIC Service is a transitional care program designed to minimize readmissions, thereby reducing costs and improving patient outcomes and satisfaction. An example of an American equivalent would be the Hospital at Home program.

I was beyond excited for my first home visit. I was eager for the opportunity to explore more of Singapore, and working alongside Singaporean medical professionals in a Singaporean home seemed like the ideal opportunity to immerse myself in this new world. It would prove to be all that and so much more.

Suddenly I found myself in a patient's home, meeting the family, the caretaker, and the patient. Out of the harsh lights of the clinic, removed from the labyrinthine corridors of the hospital wards, I saw patient as person more than ever before. Not another note to write, not another room on which to round, but a person. Although our patient's speech was impaired, I learned her story from her devoted adult daughter, whom I would come to know well over the course of my year in Singapore. I heard all about our patient's recent birthday celebration. Our patient was a well-respected and adored member of the community and received a seemingly endless procession of guests on her birthday. Unfortunately, our patient had taken ill shortly thereafter and required our medical services. Normally I would have been annoyed at the foolishness of the daughter for letting her fragile mother receive so many visitors, but as I sat sipping tea with the patient's daughter, I marveled at her openness and generosity. What I would have previously perceived as foolish irresponsibility, I now recognized as an act of love. In clinic or on the wards I would have impatiently dismissed the small details of the birthday, such as how our patient's visitors would play hymns for our patient while she did her best to sing along. In her home, surrounded by her possessions, her family, her life, our patient's story became my story. Caring for her was the only thing that mattered.

I would see this patient and her daughter a total of four times during my year-long stay in Singapore. I saw her in various states of health, and my experience with her completely changed my outlook on what it means to be well. Whereas previously I would have taken one glance at this bedbound, speech-impaired woman and assumed her quality of life was unbearable, I soon learned that this lady had good days and bad days just like anyone, but she remained cheerful regardless. Despite our patient's speech challenges, she was able to communicate basic phrases. We would ask her how she was doing and if she was in pain, and she would reply as best she could. Only after repeat visits did I learn that

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our patient exhibited a stoicism I had previously only seen in the most seasoned male veterans back in the States. Our patient never let on that she was in any discomfort until our physical exam revealed a tender abdomen or a crack in the skin. I admired our patient's toughness, but her reluctance to express her discomfort could have put her health at serious risk if we had not had the opportunity to understand her better over the course of several visits. I could not say with certainty that our relationship with this patient saved her life, but it absolutely spared her from unnecessary hardship and hospitalizations. For me, visits to this patient's home yielded their own rewards, from stimulating conversations with the patient's daughter over tea, to an expression of gratitude from a lady for whom any attempt at communication was a great effort.

On my visits to other patient homes, many similar stories would unfold. The details were different: the faces, the languages spoken, the size of the houses; but the openness, kindness, and generosity were all the same. The unfailing devotion of the families to their ailing loved ones made me see those frail yet resilient individuals with new eyes.

I want to be an orthopedic surgeon. I want to fix up relatively healthy people and send them on their relatively healthy way. I find it easy to relate to the child who broke his arm on the playground or the young adult with a sports injury. I was that person. I am that person. But if I think that I have more in common with the 20-something athlete than the elderly bedbound patients on the HBIC service, then I am delusional. After all, I am human, and I will one day leave this world, the same as everyone else. I look with great admiration to those individuals approaching the end of life, and I desire the same dignity when my life is nearing its own end. More than any conversation I have had with a patient in clinic or on the wards, the silent suffering of the patients on the HBIC service reminded me that my calling is not to merely fix what is broken, but to care for people.

Some say the jury is still out on whether Hospital at Home services can improve outcomes, avoid or shorten hospital stays, or reduce healthcare spending [7-12]. I cannot argue with their systematic data analyses and statistics, but I would counter that the more sophisticated the tools at our disposal, the easier it becomes to miss the point entirely. On a visit to one of our patients, we determined that he would require hospitalization to help him fight a lung infection. Did we prevent a hospital admission? No. Did early intervention shorten this patient's hospital stay? I would like to believe so. Did the fact that we stayed with the patient until the ambulance arrived provide immeasurable comfort to the patient's anxious family? There is no question.

Based on my experiences with home healthcare in Singapore, I believe there is still a place for the "country doctor" in America. The country doctor's traditional horse-drawn carriage and iconic black bag may have evolved into a motorized van equipped with high-tech equipment, but the mission remains the same: to tend to the well-being of the whole person, recognizing the importance of family and community in the process. This mission is the cornerstone of my own American medical tradition, yet I never truly understood my calling to serve until I lived it half a world away.

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Bringing it Back to the Patient

Of all the courses we take our first year of medical school—Molecules and Cells, Normal Body, Brain and Behavior, Body and Disease, even Practice Course—not one has in its title the name of that future individual we will some day serve: the patient. In a time when there are hundreds more illness narratives written by patients and their caregivers than there are anatomy textbooks, I believe we are overlooking an incredible resource for learning. In addition to anatomy, physiology, and the disease processes we are currently learning, the patient experience and the lived experience with illness will be equally valuable when we talk to patients on the wards in the years to come. As future physicians, we will be more than scientists; we will be advocates and healers, we will walk our patients and their families through some of the most difficult times in their lives. We will try to empathize and somehow imagine what daily life, outside of the hospital, is like for them. We will have to make difficult, unimaginable decisions as doctors and carry the weight of our words with great responsibility. To do this we need to learn skills and be exposed early to what Susan Sontag calls the kingdom of the sick.

Using narratives is at the core a way to bridge the gap between our world as medical students and that of our patients: demystifying the complex illness experience, exercising one's ability to listen closely, and developing empathy through acts of understanding. Additionally, being able to write reflectively and journal are important skills that every doctor should practice. They cultivate what Sayantani DasGupta calls *narrative humility*, the art of mindfulness in medicine where we recognize our influence on the patient's story and become receptive to their story acting upon us in return. Narrative humility allows a point of entrance into the patient's story that physician's so often miss. During the first year, in the process of cultivating these skills, reflective writing allows us to process the medical school experience, hold onto our humanity, and come together as a supportive community. Sharing writing as a group allows us to witness our classmates and feel witnessed in return. This is vitally important because so much of the individual experience during medical school is ignored or actively undermined.

Two groups of brave first year students last spring and this fall elected to take this journey with me. In small groups we discussed narratives and wrote reflectively to short prompts. Imagine discussing an excerpt from Tim Obrien's novel *The Things They Carried*—"Some things they carried in common. Taking turns, they carried the big PRC-77 scrambler radio, which weighed 30 pounds with its battery. They shared the weight of memory. They took up what others could no longer bear. Often, they carried each other, the wounded or weak."—then writing to the prompt: "What are the things you carry?"

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Or reading poems like this one by Karen Peacock:

You Don't Have to Put Your Teeth in for Me

He pulled the covers over his shedding skin,
Put a napkin over his phlegm-filled cup,
Turned the volume down on the TV
And up in his ear,
Cleared his throat through the foggy mask,
Tipped the seat down to his bedside commode
As he reached for his teeth,
And I said, *You don't have to put your teeth in for me.*

After close reading and a lengthy discussion, you then spend four minutes responding to the question: "How do you prepare to see a patient?" Sometimes we write with metaphors, sometimes specific styles. Always you have the option of writing whatever is on your mind.

The response to this work, to the fortification of these skills is magical. Groups come together as a community, supporting and learning from each other. Anonymous feedback I gathered from students at the end of their first year suggests that patient stories and narrative practice picks up where the curriculum leaves off.

One student appreciated, "Being vulnerable, recognizing all the things I still have to learn, and talking about painful things that, otherwise, I might not have an opportunity to." Another said, "We were able to really talk about issues that are important for future doctors to really be thinking about." Another observed, "I gained so much perspective into the lives of patients."

Often students will initially feel unsure about reflective writing but they all seem to take something positive away from the experience. About the reflective writing one student said, "I was surprised how much I liked them! ...it was very cathartic overall, and I'm happy for it." Another had a similar experience, "I was actually surprised that I felt comfortable sharing my writing, but I did. I really enjoyed the writing, which also surprised me. I think it helped me work through my ideas and feelings about some things in my life, and it also felt like a tremendous stress relief to get things off my chest that I was feeling at that moment."

Another person commented on the ability of writing to bring the group together, "I love the writing exercise. … I loved hearing what my classmates read, and I also felt closer to the people in the group after I shared."

I am very thankful for all the medical students who have contributed to this community and for their encouragement. As one student commented in her feedback, "I understand what narrative medicine is and why health providers need to know what it is! Keep spreading the good word."

Accordingly, I bring you the good word. There is a place for the patient in our learning during first year and what better way to practice than through narrative. I hope that I have been able to paint a picture of narrative medicine at Duke, please let me know if you have any questions or comments. The Narrative Practice Group currently meets once a week—please join us if you are interested!

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Photo by Anna Brown, at Eno River State Park

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The Human Spirit

Did you know…

About one third of the human race has 20-20 vision.

Your nose can remember 50,000 different scents.

It takes 17 muscles to smile and 43 to frown.

http://icantseeyou.typepad.com/my_weblog/2008/02/100-very-cool-f.html

I stood in the corner of the cramped room, peering over the medical record of the young woman sitting in front of me. As Dr. K carefully removed the patient's wig, she began to cry. The 23-year-old mother had recently been diagnosed with brain cancer. Minutes earlier I had seen her brain scan with more than 10 small white spots, tumors. As a 21-year-old student, I could not imagine the burden that cancer placed on her young family. Yet I consciously set aside thoughts that cried out "It's not fair!" and gently pressed tissues into the patient's hand. She dabbed her face and then suddenly paused, looking up at Dr. K with teary eyes that shone with fierce determination and a visible twinge of fear. "I'll do anything," she said in a wavering voice. "I'll drive here every day, I'll take whatever medicine I have to so I can be here for my family." As she glanced over at me the look in her eyes perfectly embodied one of my favorite quotes, "There is something inside of you that is greater than any obstacle."

Faced with adversity, this young mother chose to fight to preserve her life for her family. This determination and strength forms the essence of the human spirit. In that moment, looking into the eyes of the young mother, I was abruptly shown the tragedy that disease inflicts and thus discovered my own reason to become a doctor: to preserve the human spirit.

As a biomedical engineering major, choosing between engineering and medicine for my future career was difficult. Through my shadowing and volunteer experiences, I discovered that the crux of medicine is human interaction between doctors, patients, and medical teams. Engineers are on the periphery of this central interaction, while physicians personally facilitate growth and healing in patients. This fundamental difference is why I am becoming a physician.

Each shadowing opportunity has strengthened this decision. My first shadowing experience, with the gregarious and caring radiation oncologist Dr. R, was as memorable as it was formative. Dr. R's interactions with his patients really resonated with me. Despite their difficult battles with cancer, his patients always smiled when he entered the room, anticipating his jokes and genial conversation. Later shadowing Dr. B, I witnessed his empathy while listening to patients' concerns and his wisdom while leading his medical team. From Dr. B's exceptional mentoring, I learned that excellent physicians know how to delegate tasks and deliver results. During my final shadowing experiences with brain tumor specialist Dr. K, I witnessed how treating brain cancer requires compassion and the ability to cope with the tragedy of each patient's story.

My shadowing experiences have inspired me to preserve the human spirit to cope with tragedy and defeat adversity. I firmly believe medicine can heal both the body and the spirit, and I hope to emulate the compassionate traits of the physicians I have shadowed as a radiation oncologist in the future.

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Would you like to contribute to the next issue of VOICES?
Contact our editing staff at dukemedvoices@gmail.com

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Top: *Hanauma Bay, Hawaii (snorkeling trip after the Nov 2012 AMA Interim Meeting)*
Middle: *A group of MS1's at the Davison Council Holiday Party in Dec 2012*
Bottom: *Serene reflections of fall colors during a hiking trip at Eno River State Park in Dec 2012*