

Gold Humanism Honor Society

The following pages contain individual essays written by students of the Gold Humanism Honor Society, a national honor society that aims to highlight compassionate patient care and humanism within the field of medicine. Many students showcase narratives that highlight interactions with patients that taught them not only how to manage disease medically, but also important lessons about the human condition - how to treat all those who seek our help with empathy and understanding. We hope that the examples that follow inspire all those who read it to provide holistic care to all our patients.

◆ **Mohammad W. Aref**

She brought her husband to the ED; he wasn't feeling well. Shortly after he arrived, his heart arrested and she was rushed out of the room. We went to update her. The doctor did all the talking, I just stood by her, put my hand on her right shoulder and squeezed gently. Her husband regained a normal heart rhythm but needed to be intubated and was rushed to the cath lab. We went to update her. I didn't say a word. The doctor did all the talking; I just stood by her, put my hand on her right shoulder and squeezed gently. Her husband had 100% stenosis in his left circumflex and a massive MI. He was not arousable and was rushed to the ICU. And for the next few days on rounds, when we arrived at her husband's room and gathered around our patient, I took my position on her right side with my hand on her shoulder, didn't have a word to say, and squeezed gently. Her husband's heart, kidneys, and liver were failing, and his brain was injured, maybe permanently. We held a family meeting in hopes of better understanding his wishes, and I didn't really know where to stand. She looked at me with tears in her eyes, and smiled, ushering me to my position on her right side and reached to put my hand on her shoulder.

Months later, I was in the hospital lobby when I noticed a woman in a wheelchair smiling ecstatically at me. At first, I did not recognize her, but then I remembered my place - at her side with my hand on her shoulder. She turned her neck and looked up at her daughter who was pushing the wheelchair and said, 'that's him'. Her daughter laughed and said, 'She can't stop talking about you - the best doctor in the hospital'. I wonder if she noticed that this 'doctor' didn't write a single order, didn't perform a single procedure, and barely said a word.

I was humbled to know how simple kindness can be - a hand on her shoulder.

◆ **Michaela Campbell**

"Is there anything else I can help you with ma'am?" I end every patient encounter with a similar phrase and usually hope the answer is no, because as a medical student I tend not to have answers to a lot of patients' questions. As I get ready to walk out the door, my patient responds, "Actually yes, I'm feeling pretty lonely today, and since you asked would you mind sitting and talking with me for a few minutes?" I put aside anxious thoughts of all the other patients I had to see before meeting with my attending and decided I could give her a few minutes, as listening is one thing I am qualified to do as a medical student. We talked about her experiences with polio, the painful death of her husband, and her children and grandchildren that are often too busy to visit her. Although it's like we talked for hours, I was only in the room for an additional 15 minutes and still had plenty of time to see my other patients. But with that short conversation, I developed a strong understanding for my patient as an entire person, and she felt like the healthcare team truly cared about her. This basic interaction once again reminded me how important humanism in medicine is. People should feel like they are being treated as humans - not just as a disease. Taking a few minutes to form a connection helps patients feel heard and gives them greater trust and confidence in their care team. Finally, this encounter helped me realize that although there are many things I can't do as a medical student, I can still be a valuable asset in one of the most important aspects of medicine: compassionate and humanistic care.

◆ **Jennifer Choe**

I met a patient during my VA Internal Medicine rotation. He was a 63-year-old male who came into the ED with a severely necrotic left leg secondary to peripheral vascular disease. He had been on antibiotics for months but finally came into the ED because he could no longer tolerate the pain. Upon first meeting me, he made it clear he did not want an amputation and that he wished to only have his pain controlled with the help of palliative care. This was baffling to me because he was otherwise relatively healthy and most likely would have a long life expectancy if we were to remove the infection source. I argued with him in the beginning and we even brought Psychiatry on board. As we got to know each other, he opened up about his life and how hard and lonely it had been to be the sole caregiver of his wife who had suffered a hypoxic brain injury. He had not been able to take care of himself and now he was terrified of possibly being brought back after a cardiac arrest with a similar outcome as his wife. He was strict DNR and did not want to risk going under anesthesia. He was tired and wanted to be comfortable. I did not agree with his decision but he taught me that ultimately as a physician you need to respect the patient's wishes. All you can do is be there for them and do what you can do to make them feel physically and psychologically comfortable during a very difficult time in their lives. I felt ashamed I had judged him initially for allowing his leg to get this bad before seeking help or that I just assumed he was giving up. After I was done with my service I visited him to eat M&Ms and watch TV with him a few more times before he was discharged with hospice. He taught me that we have no idea what people have been through in their lives and that if we give them the opportunity to tell you their life story you can come to understand and respect their decisions.

◆ **Kyle Davis**

As a medical student it often feels difficult to find meaningful ways to contribute to the care of patients. You can get trapped into trying to find "medical problems" that you can address that have been ignored by other members of the team. But luckily, as a student you have one thing that other healthcare providers may lack, and that is time. Time to spend that extra twenty minutes to explain the treatment plan, time to learn more about their family, or time to just give the patient someone to talk with to lift their spirits.

One of the most impactful patient interactions that I experienced during my clinical rotations involved a young boy hospitalized for a cystic fibrosis exacerbation. He was not one of my assigned patients but through the week I would hear about him during rounds and would say hello from the doorway of his room. Most mornings he was alone because his mother was taking care of her other children at home. He looked uncomfortable as he sat in bed playing video games gasping for breaths through his BiPAP nasal mask. I wanted to help this patient but what really could I offer that has not been addressed already by the resident and attending. One day on rounds the resident mentioned that the patient was begging her to play video games with him. Immediately, I regretted that I had not thought of doing this days earlier, as it was something that only required extra time. Later that day, another medical student entered his room and challenged him to a round of Mario Kart. His eyes sparked open and he began to smile. He was ecstatic and it felt amazing to provide him a little joy during his long hospital stay.

Obviously, I probably won't be able to play video games with all my patients in the future, but I will do my best to look past just the "medical problems" at hand and try find simple ways to lift their spirits.

◆ Maritza Gómez

Taking a patient's history is a necessity in medicine, and for me, it is also an opportunity to gain insight into the lives of my patients to help better understand them. One patient, in particular, exemplified this more meaningfully than I ever expected. S.D., a 64-year-old Hispanic male with systemic amyloidosis, was likely too complex a patient for a student on her first rotation. However, as the daughter of immigrant parents I understood intimately how language barriers interfere with medical care. For this reason, I felt called to support him throughout his extensive stay by being someone who could advocate for his needs in his native language. While listening to his history, I learned that he had three children and that he was an avid reader. I formed a relationship with him and his family and, when they were not there, I called to update them on the status of their dad, as that is the kind of treatment I would like my own family to receive.

Serving him helped me reconnect with my love for medicine, as I felt that I made a strong connection with him. He was the kind of patient that was always remembered by medical teams because he always had a smile on him. Once his condition started deteriorating, he was transferred to another team. However, I continued to visit him as he was always filled with gratitude when I came. We used to converse about books, listen to music and sometimes I would read to him.

When his FiO₂ maxed on the bipap machine, I informed his family that, unfortunately, he was nearing his final days. Sadly, he became my first patient to pass away, but he lives on in my memory and in the impact he had on who I aspire to be as a healer. I am convinced, now more than ever, that achieving an understanding of our patients' lives is crucial to delivering competent and compassionate care.

◆ Katherine Griffin

I met Ana early into a ten-month stay with Floating Doctors, an organization providing weekly clinics to the indigenous population of northern Panama. Ana lived in Valle Escondido, a small village in the islands of northern Panama with no electricity, no clean water and a 30-minute cayuco paddle away from the nearest city. Even further was the children's hospital in David, a three-hour taxi ride away. Further yet was Panama City, the only place in the country able to fix Ana's congenital heart defect, a 7mm patent ductus arteriosus (PDA). Ana's mom, a 21-year-old mother of 4, had no job and no way to get her child to David for imaging, let alone to Panama City for surgery. One day at a clinic in Valle Escondido, I saw a little girl sitting on the sidelines of the soccer field. It was Ana, looking longingly out to play with her peers. She then told me of her "broken heart" which she felt by placing a hand over her heart; a sign that I now recognize as a palpable thrill, a sign of a significant heart murmur. I reviewed her records and noticed the murmur documented at every visit, but no treatment plan had been discussed. I soon learned about some interventional cardiologists coming to Panama City to repair congenital heart defects pro bono. Months went by as I continued to fight and advocate for Ana. After meticulously coordinating food, transportation and housing, I was able to accompany Ana and her mother to Panama City for surgery. After riding all night on a bus, we walked into the hospital and checked in for surgery. We sat eagerly in pre-op while whirls of people checked on us. After Ana returned from the OR, her mom placed her hand lightly on her daughter's chest, looked at me with tears in her eyes and said, "It's gone. Thank you." And so, I say to my future self, my future colleagues, and my future patients: keep persevering. Keep fighting to overcome each and every seemingly insurmountable barrier and keep advocating for those who can't.

◆ Emily Hentz

"This next patient is an elderly woman, here for follow up on her blood pressure," I was informed before seeing her at the family medicine clinic. An all too familiar chief concern in primary care, I went in and began my standard screening questions. A few minutes into my interview, her responses to my light probing regarding depression and anxiety prompted further questions as my concern for her mental health increased. This interview unearthed her life story: a child abandoned by her parents, sexually abused at a young age, then thrust into an abusive marriage, an immigrant struggling with limited support in a foreign country, her only son passed away at a young age due to medical conditions, and now having difficulties taking care of her aging husband on her own. By the end of her social history we were both tearful, and yet she was offering me a tissue.

Apart from her story being quite poignant, it left a sense of awe at how well the clinic and my preceptor have done in aiding patients in this community. She specifically noted that her motivation to keep herself healthy has stemmed from this clinic. "Aqui hay amor," she boasted, referring to the love and support she received from the staff at the clinic amidst the loneliness and lack of support that has permeated her life.

This is the kind of physician I aspire to be. An extra ten minutes spent genuinely listening to a patient's background can create the trust needed for a patient to be motivated in their own self-care. I hope to continue to acknowledge and validate my patients' experiences before working with them to address their physical needs. Building strong, lasting relationships that enable me to empower patients to improve their health is what I look forward to as a future physician.

◆ Guadalupe Jimenez

Throughout my clerkships, one family in particular reminded me of why I decided to change my career and become a physician. My patient was 7 years old with intussusception as a result of HSP. Her father spoke Burmese and was unable to communicate with me or any of the staff. The patient was stoic but brave. She spoke with the surgeon and they informed her that there was a chance that they would have to get surgery. The surgeon used the translating services to communicate with her father. After the surgeon left, I was curious on their understanding, so I applied the teach-back method. I realized that even though the translating services were utilized, her father didn't have a great understanding of the potential gravity of the situation. This hurt me because I knew that he was in fear, he was scared for his daughter's health. I know from personal experience that he has made taken extraordinary measures to ensure that his daughter grows up in an environment free from unnecessary threats to her well-being. Families come to country hoping to escape war, violence, poverty etc. They want what's best for their families but often find themselves helpless in certain situations. Recognizing that this was the story of my family, it touched my heart and I remembered why I entered medicine. I want to advocate for families like them until the day I retire. It's often more time consuming to have to use translating services, but it's necessary. I would lovingly encourage everyone, do your best to ensure your patient is receiving the same information as all of your other English speaking patients. Always keep in mind that they are fearful, and the best way to fight fear is with information.

◆ **Sandra Jones**

Patients deserve a vote of confidence in the same way one would encourage a teammate, coworker, or loved one. One of my patients had survived a terrible MVC and regained consciousness. Everything hurt, she was unable to move, and she was afraid. Each day my colleagues and I told her our medical plans to keep her as informed as possible, performed thorough exams to catch everything we could, and went on our way to let her retain at least a measure of privacy. And yet every day it was evident she was miserable. One afternoon, I decided to stop by her room and saw her mom telling her that she can do this, that she has made a miraculous recovery, and showering her with encouragement as she worked with physical therapy. I specifically remember how the mom told the patient “I’m so proud of you.” As soon as she heard this, brightness flooded her eyes and a smile spread across her face. That next day I saw her listening to music and even making jokes with her care team for the first time in her 40+ day hospital admission. She was working harder than ever with physical therapy and seeking more insight into her care. Though part of an amalgamation of reasons why she was improving, it was clear that the moment she and her mother shared was imperative to her improvement. I had no idea that pausing the medicine to lift her spirits could mean so much for her recovery. This realization was magnified when I recognized how little time my colleagues and I had spent acknowledging her emotional state. Caring for her taught me about the invaluable role of encouragement, even in the modern era of advanced surgical techniques and life preserving technology she was dependent on. This moment helped me see that medicine cannot work its best if it’s not paired with a whole lot of positive human reinforcement.

◆ **Nicholas Elias Kalafatis**

I was once rotating on internal medicine and during my inpatient rounds, the physician I was with was absolutely brilliant. His only downfall, I would say, was that he often had difficulty communicating with patients about their diagnosis in layman’s terms. One time in particular stood out to me because the patient turned to me during the physician’s summary with a look of confusion and proceeded to ask me to describe what is going on. I felt embarrassed for the doctor who was trying to explain to the patient what was going on with their health but on the same note understand that for the patient, this is a difficult time in their lives and they do not understand all of the medical terminology that we so effortlessly use on a daily basis. This memory has taught me that my role as a physician is not only to treat disease but also to teach disease to my patients. I love to educate my fellow peers or underclassmates on topics, and I feel like I have a calling for teaching as well and hope to teach someday in the future. Moments like this where you get to educate a patient on what is going on with their body feel exhilarating for me because understanding and learning is something that I feel everyone can appreciate and enjoy.

◆ **Mathew K. Marsee**

“How am I supposed to care full time for my husband with end-stage dementia AND fight my own cancer at the same time?!” she said to me during my first week on the general surgery rotation. I was only a month into my second year in medical school when the general surgeon I was following sat down with a woman in her late sixties to break the news that she has metastatic breast cancer. This kind, gentle woman had come into clinic two weeks prior with a massive necrotic mass growing off of her left breast. I’m going to tell you how this interaction changed the way that I look at a physician’s role as a healthcare “provider”. How our role as educators is arguably as important to our patients’ outcomes as are our diagnostic or therapeutic skills.

Our patient told us that she “knew it was bad”, but that she put off seeing a doctor because she didn’t “have the time or the money to take care of this right now with everything going on with [her] husbands’ dementia”.

Following that visit, the surgeon told me that the hospital has a mobile mammography truck that holds yearly events relatively close to our patients’ home; and that prices are based on patient income. “Are you kidding me?!” I thought. There is a resource that could’ve caught this cancer earlier and potentially the life of this patient (and by default her husband who depends on her care); and it’s both convenient AND affordable?!

◆ **Joshua Mifflin**

I used to shy away from human suffering. Not just physical avoidance, but mental blocking, numbing myself subconsciously instinctually. As a CNA in a LTAC hospital prior to medical school, I did not understand it. I saw it, interacted with it, but certainly did not feel it. That began to change as my experience in medicine grew.

In medicine you are surrounded not just by patients but their stories. It is truly a blessing to be in our profession. The opportunities to learn and grow from those we treat are endless. I am reflecting on a recent patient: a 50 year-old man who presented to the ED having suffered a stroke with a medication list you might expect from a man a couple decades senior with a busy medical history.

When I explained to him what the imaging showed, it was clear that it was weighing on him. The man was assuredly suffering already. His diabetes had taken half of his foot, and his functionality had been on a steady decline at a time he desperately needed it to take care of his debilitated mother. The next day on rounds, we learned he had spent years with depression and suicidal thoughts. He began lashing out on staff becoming verbally abusive as he attempted to grapple with the implications of his new prognosis. Nursing continued to struggle and emergency psychiatric detainment seemed unavoidable.

I went and listened to him. Years of dealing with undeserved suffering poured out of him as I learned about his life. I confided in my fiancé that evening on my way home telling her about his outbursts and his story. I told her I wish I had known what to say, what to do to help him get through it. I thought I’d failed.

◆ Cally Miller

Bob was an 80-year-old gentleman who I admitted to the hospital with pneumonia. He had end stage COPD and the pneumonia had really knocked him down. His wife Suzy was present with him at the hospital. They were kind, personable people and I enjoyed talking with them. One morning, in a conversation, Suzy told me that she had throat cancer 2 years before, and her husband Bob had taken care of her during that time. She was so strong, could speak well, and was doing great. I never would have known she'd had throat cancer if she hadn't told me. They continued to tell me the story of how they had cared for one another in difficult times...and all the help that they had met along the way: people who had offered to house them in Indianapolis for 2 months in an apartment so she could attend treatment, doctors who believed in recovery, and even how Bob pushing Suzy around in a wheelchair all over University Hospital had helped improve his lung function. To hear their story was such an inspiration. And then they continued by thanking me. They said that they felt that medical professionals never got enough appreciation, and that they felt so happy with the care they were receiving at the hospital where I was rotating at that time. They also took time to encourage me and it was a major blessing to me. This was the first time in my medical career that a patient had thanked me for care I was providing, and it was both a humbling and reassuring experience. I will always remember Bob and Suzy. Sometimes we are there for patients and feel like we are not appreciated, but just taking extra time to chat with them makes a big difference. It's a reminder that if we continue to see our patients as people—rather than just another disease entity such as COPD or diabetes—both the patient and we ourselves can be blessed in ways that we could never imagine.

◆ Amit Nag

On my first day of inpatient internal medicine, I was assigned to a patient who would end up being on our service for longer than we expected. He was admitted due to anasarca and taught me at least two things: what does anasarca mean (after a brief google search on that first day, I learned it meant generalized swelling around the entire body) and how our interactions on a human level aid our ability to teach and heal. The service happened to be slow when I started, and so I was allowed that which all doctors want more of with their patients: time. In my early morning pre-rounds or in the afternoons when he had an upcoming procedure, I was able to talk with him and get to know about his life and how this disease affected him. Like how he had a dog named Trucker at home that loved to go on walks, but who had to stay inside because his edema made him short of breath within seconds. Through the stories he told me, I was able to connect with him beyond his diagnosis and lab values, and he took it to heart when I told him that he would need to cut down on eating his favorite snack: raw tomatoes with salt. Despite that bad news, I could provide him with some hope that even though he couldn't be discharged safely that day or the next, in a few days' time, he would be able to take Trucker out on that walk. I respected him more and more as we talked, and in turn he trusted me and the counsel I provided. And one day, when he was worried that the increased dose of Lasix we were giving him would hurt his kidneys, I was able to allay his fears and educate him as to the reasoning behind our plan. He taught me that our patients have lives outside of their care, and that we can provide better care when we know more about them as people.

◆ Paige Schultheis

During my internal medicine rotation, I had an opportunity to form a unique connection with a patient on the Heme/Onc service. This patient was an aspiring singer, mother of two, and someone newly diagnosed with acute myeloid leukemia (AML). Despite her diagnosis of a high-risk leukemia, she was the person you saw doing 70 laps around the floor and greeting everyone with a smile. She was extremely optimistic and positive always.

She and I clicked. This was a patient who I was visiting multiple times a day just to chat. We listened to her music, talked about my upcoming exams, and of course, discussed her care daily. To my surprise, during my morning rounds one morning, she ended up confiding her fears in me and broke down in tears. In the moment, we hugged and she cried. I didn't say anything, but I was there.

This experience provided me with a first; the first patient that I truly connected with. This relationship showed me the kind of connection I want to build with as many patients as I can in my future career. It showed me that forming that connection is what can provide resilience and dedication in your care. As much as these relationships can fuel myself, I believe forming these connections will also help me understand my patient's goals in their care as well.

◆ Madalyn Vonderohe

On my first day of my Pediatrics rotation, my attending said something that has stuck with me to this day. She told us that, anecdotally, she believes patients with medical students on their care team receive better, more holistic care because resident physicians often have to spend more time taking care of their computers rather than their patients. As incompetent and clueless as I have felt this year, I have tried to keep that sentiment with me and be the best advocate for my patients as I can be, as their voices often slip through the cracks between over-burdened residents.

This story, though, is about one who refused to let her patient's care suffer, despite discovering that the medical system had already failed him. This patient had been previously healthy, a grandfather, father, husband, brother beloved by his entire family. He loved to be active, talking walks with his dog daily, visiting with the neighbors and entertaining the children of his apartment complex. You would have no idea, though, looking at him in the ICU, mere days away from his passing. What started out as simple cellulitis from a diabetic foot ulcer turned into fulminant bacteremia with massive end-organ damage, and we couldn't seem to figure out why.

My resident refused to let him go without figuring out what happened. She dug through his chart, spoke to physicians, nurses, family, staying at the hospital beyond any of her colleagues in order to put the pieces together. Ultimately, through all of her digging and her persistence, she discovered that due to a miscommunication between practitioners, the patient was not initially placed on antibiotics when the cellulitis was diagnosed, allowing the infection to spread to the bloodstream. This delay in care ultimately led to the likely preventable death of this patient, the loss of a grandfather, father, husband, and brother.

While her determination and investigation into what happened to this patient could not prevent his death, it will hopefully prevent something similar from happening again in the hands of the same facility. Witnessing this all unfold taught me the lesson that you are never too busy to give your patient the best care they can get, and to constantly strive to improve the system for your future patients.

◆ **Raghav Vadhul**

As a citizen of a developed nation, I often find myself taking for granted the luxuries that I am privileged to have at my disposal. One of these luxuries, which should perhaps be considered a necessity, is my easy access to vision care. I have worn glasses since I was in middle school and would be practically blind without them. However, it is commonplace for people in the developing world to live their whole lives without access to this service. I witnessed firsthand how severely lack of access to vision care affects patients and how dramatically the work of a few compassionate physicians can change these patients' lives for the better.

I met Mr. R in Cheyyar, India the summer after first year when I was volunteering as a Global Impact Fellow. Mr. R was a farmer who had worked his whole life in the fields and had developed severe bilateral cataracts as a result. His vision was so poor that he could not even see a hand waving directly in front of his face. Because of Cheyyar's remote location and his financial situation, he had never seen a doctor that could have helped him. Mr. R could have easily been forgotten and abandoned by society were it not for the compassionate physicians that decided to make it their own mission to help him and others like him. These physicians took days off from their own clinics to travel and provide free vision screens and cataracts surgeries for patients like Mr. R. We served everyone from local politicians to the homeless, and in a society where social status often defines how you are treated by others, these physicians demonstrated genuine humanism by putting the patients' humanity before some social construct of worth.

Clearly, these physicians had no personal gains from performing these services; in fact, they likely lost capital from missing clinic days. However, they understood the greater impact of serving their community and helped me understand what my pledge to "practice my profession with conscience and dignity" looks like in practice.

◆ **Celestina Okoye**

The first two years of medical school was a whirlwind of being in the books and constantly stressing about each upcoming exam. I often looked forward to the end of second year and finally being able to see patients. When third year arrived and my Pediatrics rotation started, I was excited to finally have more patient interaction; however, this emotion was entangled with nervousness around adapting to a new environment. Towards the end of my month on inpatient pediatrics, I was assigned to an 18-year-old girl. I introduced myself to her and her father who was in the room and began to take an initial history. She had been diagnosed with lupus a few years ago and had frequent flare-ups that required hospitalization. In the afternoons, I would have time to go and check on her and, in this time, I learned a lot more about her. She often talked about her dreams of becoming a cardiothoracic surgeon. We also talked about her prom coming up and the dress she was going to wear that her father made himself and we looked together for matching shoes. Her father was so proud of her. He talked about how worried he was that her flare-ups would keep her from accomplishing her dreams, but he admired her determination and resilience. When it was time for her to be discharged, her father asked to speak with me outside of the room. He thanked me for making his daughter feel "normal" and taking the time out talk about other things besides her lupus. I told him how much I appreciated his kind words and I knew this would leave a lasting impression on me. This experience reminded me of my belief that at the core of every human is the desire to create meaningful bonds. Along with building these bonds comes compassion for one another. If we continue to remember that in the stressors of becoming physicians who will be taking care of many sick patients, we will be able to continue when times become tough.

◆ **Kirsten Zborek**

In our first two years of medical school we routinely talk about giving bad news. This usually takes place in a classroom, in a textbook format, without real patients, and pretend bad news. However, observing real bad news delivered to real people doesn't look or feel like what we practice. I've observed physicians giving diagnoses, unfavorable lab results, or poor outcomes. Sometimes it goes well, with both the patient and physician agreeing on treatments and understanding their prognosis. Other times it doesn't. During my third-year rotations, I can recall one event that went particularly poorly. We were seeing a patient in the Emergency Room for a seizure. Unbeknownst to the patient, his hemoglobin A1C was 10%. We did not believe his newly diagnosed diabetes was the cause of his seizure. On our way to see the patient we let the attending know the patient did not yet know about the diabetes diagnosis. Maybe it had slipped her mind by the time we got to the room, but she began the conversation talking about "your diabetes". Not only was the patient in shock and disbelief, but so was I. These few words would change how the patient lived his life and my heart ached for him. We dropped this bad news on him with little explanation or empathy and left the pieces for another physician to pick up. When the patient further questioned what his new diabetes diagnosis meant my attending said, "Your primary doctor will help you", not realizing he did not have a primary physician. I left that encounter confused and saddened. As I reflect on this experience it's easy to pinpoint what went poorly. In contrast, I've found it more difficult to identify what goes well in positive interactions. One lesson I have taken away from my third year clerkships is that physicians who continue to show every patient compassion and remain sensitive to the burden their words may carry undoubtedly built a better relationship with their patients.

◆ **Mackenzie MacGrath**

On my medicine Sub-I, I helped take care of a man named Mr. D. He was admitted for reported rapid onset ascites and jaundice. No one knew what was wrong, but after multiple rounds of testing he was thought to have alcoholic cirrhosis. His presentation was unusual, and his vitals and labs were not consistent with that etiology. I didn't believe what everyone else thought.

I had good rapport with Mr. D, and a large portion of my time at the hospital was dedicated to his care. After a long day on call, my resident asked me to go check on him before heading home around 2230. The next morning as I pre-rounded at 0600, he asked me if I had even gone home - because I was the last person he saw before going to bed and the first person he saw that morning.

The last thing I said to Mr. D was that I had a day off, but I would see him on Monday. Over the weekend, he was transferred to another hospital. I was a little surprised but very relieved as this hospital was the best place for him. Then the COVID-19 pandemic hit, and medical students were removed from the clinical environment. In those initial days off, I frequently thought of Mr. D and was very curious about his outcome. When I texted my resident for updates, I was given the shocking news that he had passed. I was devastated. I have experienced death before, but the loss of a patient was different. I still don't quite have the right words to describe all the emotions that flood my heart, but I feel humbled that I helped with his care. Mr. D will be a patient that I will remember for a very long time.

◆ Shae Jensen

No one had told her, but she was dying - heart failure at 31 years old. Years of IV drug use that resulted in endocarditis, now leaving her with a failing heart. Her legs were swelling, and her lungs repeatedly filled with fluid. She kept leaving against medical advice, presumably to indulge her detrimental addiction. We either assumed she must've known she was dying, or we didn't care if she did, both possibilities breaking my heart. No one told her, but she was dying. And without a continuous course of intravenous antibiotics and heart valve replacement surgery, her months were numbered.

I met her on the first day of my internal medicine rotation. She graciously invited me to sit with her and shared about what seemed to weigh most heavily on her heart - her newest daughter she hasn't met yet. She had delivered her daughter prematurely 2 weeks prior due to life threatening pregnancy complications. While my patient wrestled against the last days of her life in and out of the hospital, her newest daughter fought for her first days in the NICU across the street. I asked permission to discuss her health. She knew that her heart had an infection, but she did not know that her state was critical and her heart was failing. No one had told her, but she was dying. My white coat felt even shorter than it was as I realized that educating and empowering her with information about her health could include sharing about the severity and fatality of her condition. As a medical student, I didn't know how to perform surgeries or order complex therapies, but I had the time to talk. And so we talked.

We drew pictures and talked through her disease, and as she asked more questions she began to understand the pathway by which her IV drug use led to tricuspid valve failure and the irreversibility of her disease state. Although this conversation was scary and tearful for both of us, it empowered her to be invested in her health journey and pathway to recovery. My patient taught me about the importance of learning our patients' stories, building relationships, and being on a team with our patients. She taught me about the power of empowering our patients through education. I am thankful my patient shared her journey with me.

“Whoever offered that Sabonis contract should be fired.”

Such talk may be found in a sports bar in Indiana, where Pacers players are often the center of attention. However, I was not expecting to find a critic of Domantas Sabonis' contract extension in an inpatient room at Eskenazi hospital.

During my internal medicine rotation at Eskenazi, I was lucky to be invited to watch a Pacers game with one of our patients. She was awaiting workup for a mass that was causing her significant fatigue and weight loss. Through our conversations, I learned that not only was basketball a way for her to escape the monotony of the hospital schedule, but it was also something that gave her joy and energy despite her condition. So, after I was dismissed for the day, I made my way to her room to share happiness in our mutual interest. To my surprise, I walked into a room that looked more like Bankers Life Fieldhouse than a hospital room, one that was packed full of her grandchildren.

In that moment, I saw evidence that no matter the diagnosis, patients should not be defined by their illness. Seeing her eyes brighten and face so animated when talking about the Pacers with us proved how far reaching loving relationships can be. It also reminded me that medicine is more than just interpreting lab values or findings on a physical exam; rather, it is the relationships that we build and moments like watching Pacers basketball with others that make it a profession worth serving. As a developing physician, I hope to keep this experience in mind and build lasting, holistic relationships with my future patients. I aspire to always see the person behind the patient, understanding that along with their physical health comes emotional and psychological wellbeing that must also be nurtured.

Mr. F did not want to stay in the hospital; he wanted to go home to his farm on the coast. Mr. F's daughter disagreed. Mr. F had not been on medication for a single day of his 90+ years of life until one month prior to meeting me, and he did not want anything new. Mr. F's daughter was open to medical management. Mr. F only knew he was having a stroke because he couldn't read his sheet music while playing his violin. Mr. F's daughter wanted him to make it to his upcoming birthday where his ten children and many grandchildren were planning a performance using all their musical talents, which had started with Mr. F and his wife. Mr. F, a humble and strong man, cried when he told me that his wife had died in a hospital, far away from the farm where they had raised their ten children; Mr. F didn't want that for himself. Mr. F's daughter cried when she told me how scared she was that if her father went back to the farm, no one would find him quick enough if he got sick. I wanted to cry when I experienced their tears. I didn't have a good answer for either of them; as I listened to the story of Mr. F's life, I could understand why treatments to prolong his life weren't valuable to him if he couldn't live that life in the only place he knew as home. I could also understand Mr. F's daughter's desire to take care of her father who had given her so much. When we discharged Mr. F, there still was no clear plan for where he would go long term. I've thought about him often though; I've hoped that he made it to the musical performance and hoped that he is resting at his farm. I've also thought about the lesson he gave me to remember why we do medicine—not just to fix bodies and prolong the days of life, but to help prolong the kind of days that people love to live.

I've had many inspiring experiences with patient's and patient families and am so privileged and honored to have been allowed to be a part of their care. One incidence stands out to me. It was during my Family Medicine clinic. The patient had recently lost her job and was worried whether she was able to afford her appointment that day and her medications that month. Her multiple chronic conditions leave her often immobilized due to pain. In addition to her financial and physical health concerns, she had recently started being more active to help with her grandchildren as the children's father had been recently incarcerated due to domestic violence against her daughter. Needless to say, she was feeling overwhelmed, tears streaming down her face. And although we provided her comprehensive management of her chronic conditions and additional community resources regarding her other social considerations, it seemed that my preceptor could sense that something else was needed. She knew the patient well and offered to say a prayer for her and her family. In that small moment in which we prayed in this tiny exam room, I could sense, even if just a little, there was a weight lifted off the patient's shoulders. The prayer not only acknowledged the patient's struggles, but also offered hope that like many bad times, this too shall pass. This showed me the importance of building a relationship with patients and how often times the little things outside of “medicine” are the most important parts. It is the “art of medicine.”

The first time I met KA, the small 3 year-old Mexican boy was terrified at the sight of any physician. He was crying and screaming and all that was running through my head was how can we help you. His mom was trying to calm him down but nothing seemed to work. She seemed very shy and embarrassed (but I do not mean this in a negative way) at her son's behavior. Over the next few days, KA became known as the "cryer" and the patient that no one wanted to go see, but this inspired me to get to know him and his incredible mom, who was with him 24/7 despite having 3 other children at home. Slowly KA started to warm up to me. Every time I saw him all I could think of was how resilient he was, he had already undergone chemotherapy and an organ transplant in almost the same amount of time that I have been in medical school. The little champ had a great sense of humor and a sly personality. We found out a couple of days into his stay that his crying episodes were due to intussusception, and he was treated appropriately. On my last day of the rotation I knew I could not leave without saying goodbye. When I entered his room, I knew that I was not only saying bye to him but to his entire family whom I got to know well. For the past two years, I have run the Monumental Marathon to give my medal away to a true champion, a fighter. This year it only felt right to give it to KA. I can still perfectly picture his face when he first saw the medal; he could not believe it belonged to him. The medal was bigger than his palm, and he would not let it go.

Ever since the day I said bye to you, K, I think of you. I think of all the potential you have in you, and I just hope that one day you realize that you have made a huge impact on my life. You were more than a patient to me—you became my motivation. I will continue to run and get to know all the "difficult" patients, but most of all refrain from labeling someone as "difficult" but instead take the time to know them as a human.

One of the prevailing pieces of advice that I heard before heading overseas to work at the Moi University Teaching Hospital was to be prepared for people to have conditions that could be treated in the United States, but not in Kenya, and for some of them to die because of it. I had months to think about this, and by the time I was getting on my flight in Chicago to leave, I thought I would be prepared. I wasn't prepared.

While on the female adult ward, it wasn't uncommon for us to have multiple patients with conditions that stemmed from an underlying chronic lung disease. Whether that be right heart failure, a superimposing secondary pneumonia, or a straightforward COPD exacerbation, we treated it all, and most people recovered. One of my first days on service, we had a patient come in with a relatively uncomplicated COPD exacerbation. We treated her with steroids, inhalers, and azithromycin, and initially she looked a lot better. Normally I wouldn't give this case much of a second thought. In the United States, they often would get better, and if they didn't we could transition them to BiPAP support as a bridge until they did improve. However, we didn't have BiPAP there, and she didn't improve. Over the coming hours she progressively went into worse and worse hypercarbic respiratory failure, and we weren't able to transition her over to ICU level care because of a lack of beds. Unfortunately, she passed away, and I felt terrible for letting something so straightforward become the cause of her loss of life.

When reflecting on this, there wasn't anything else that could have been done based on the situation that was present. We simply just needed supplies that weren't available to us. However, this experience has impacted my current path as a developing physician. It was a humbling experience to realize that even with all the knowledge in the world, health outcomes are still so dependent on the things we have and the barriers to care that are present in an area. I am committed to advocating for those faced with these types of disparities, and I hope that I can be an instrument for preventing these deaths in the future.

CJ was admitted again as the painful expansion of her abdomen and yellowing of her complexion bore evidence to fluid that kept accumulating. This pattern had repeated itself over the past weeks, with paracentesis only providing temporary relief. Each hospitalization stabilized her until the encephalopathy resolved. She needed the definitive fix of a liver transplant yet didn't have a high enough MELD score to qualify. Additionally, she had recently become uninsured, and without drastic intervention, she would not live to reach 65 to qualify for Medicare. CJ had no family in the area, her closest son a flight away. She knew the gravity of her situation but never complained. As I went each morning to check on her before our neurology team rounds, it was bittersweet. She expressed her gratitude for the consistency of our short morning visits, but I felt frustration at what little I could do in the big picture. Near the end of the week, our team had an afternoon where we had finished seeing all our consults, so I went back to see CJ. We sat for half an hour, talking about her family, hobbies, projects she had at home—anything besides treatment options and medical care. When I eventually had to leave, she thanked me for taking the time to come sit and listen. Even without having any new answers for her, I left that day feeling that those 30 minutes were the most meaningful care I had been able to provide all week. In the daily rhythm of rounds, consults, orders, and charting, it can be easy to lose sight of the shared need for human interaction, the need to be seen beyond the roles we inhabit as patient or physician. That encounter was a reminder to strive to see my patients as the individuals they are, for their lives outside of the space in which we interact

Mr. V is a father, a grandfather, a lover of nature documentaries, and a huge fan of Coca-Cola, who happens to have end stage renal disease at the relatively young age of 54. I had the privilege of being a part of his care team when he was admitted to our medicine service with anemia and, what we thought was, an elusive GI bleed. He spent two weeks on our inpatient service undergoing invasive procedures to diagnose the bleed, but we could never find it. All the while, he was getting blood transfusion after blood transfusion and maintaining his weekly dialysis schedule. Mr. V was also what most healthcare professionals would call a difficult, or non-compliant, patient. He frequently refused medications and blood draws from the nurses, opted out of speaking with the medicine team on morning rounds, and even denied visits from his family members. I did not blame him, because I would be grumpy too if I had spent weeks in a hospital without answers. One day, after three straight mornings of him refusing to speak to me when I pre-rounded in the morning, I asked him what had been the most difficult part about this hospitalization. He replied, "Being scared." I asked him what was frightening him, thinking that it would be the life-threatening anemia, but he looked at me, rolled his eyes, and said, "Needles, I am deathly afraid of needles." I reflected over his time in the hospital recognizing that almost every aspect of his treatment had required being stuck with a needle. He told me that to combat this during his dialysis appointments his daughter usually comes with and lets him squeeze her hand as the needle goes in. From that point on, our team's care plan focused on minimizing needle sticks, and I was given my job as the designated hand squeezer for the remainder of his hospitalization. It was incredible to see how us taking Mr. V's fears, priorities, and preferences into consideration transformed him from "difficult patient" to the kind father, grandfather, nature documentary lover, Coca-Cola fan, and patient that he was.

During my inpatient pediatrics rotation, I picked up a young patient who had just immigrated to the US with her mother. She had gotten ill during her time in a detention center and was having serious trouble breathing by the time she arrived in the hospital. There was an obvious language barrier, culture shock, and lack of trust affecting the patient's mother. We were able to treat her daughter quickly and while she was initially transferred to the PICU, she was able to go home within a few days. This patient interaction is one of the most impactful patient interactions I have experienced. Witnessing a patient in our community who had such a clear tie to far-reaching global health was unexpected for me. From this interaction I was able to see first-hand how easily a young child can go from healthy to gravely ill simply from being held in a location without readily available access to health care. Being on the team treating this patient reinvigorated my passion for addressing health care inequities both in our local community and abroad. Working with this family challenged me to understand what my role will be in the future treating patients who are affected by the political climate in this country. It's clearly a topic that many disagree on and I learned an important lesson in balancing my role as a physician and my role as an activist in our local community and our country.

Serving one another is vital for the flourishing of an individual and community. Medicine has helped me to recognize this truth. It is where I feel most alive and serving in this way further drives my passion to live by this truth. One such instance was on my Palliative Care rotation. My staff provided wonderful guidance but gave us autonomy when navigating difficult conversations. My first instance of delivering horrible news of malignant cancer with a prognosis of weeks to live was to a hardworking man who was estranged from his son. Work was so vital to his identity that he was still fielding calls from his crew while he was in the hospital in significant pain. This initial delivery of bad news became something I did daily, as he dwelled in the denial portion of the grieving process for a whole week. Every day, I spent at least an hour talking about his construction work, how much he missed his son, his stepdaughter that took care of him, and how Speedway has the best creamer, but Starbucks has better coffee. However, he would not tell his family his diagnosis, claiming that he would call later, on his own time. Eventually, I was able to call his family with him, and informed them of the extent of his cancer. The news seemed to finally hit him then that he was going to die soon, and he started to cry. Not too long after, he passed away. After debriefing with my staff, it struck me that this was my first instance of caring for an individual to their death, rather than toward the hope of healing. As physicians, one can be continuously working toward the next cure, but many times, the answer on how to best serve a patient is to be present, and work toward a peaceful death.

There was something different on my resident's face. I could tell as soon as I walked into our team room that morning. I had seen A LOT of difficult diagnoses in my first week of the Heme/Onc wards but immediately knew this morning was different. What are the odds that two little girls, the same age, would come in with similar leukemia diagnoses on the same night? Our team geared up for rounds, knowing even though we were about to give very treatable diagnoses to these families, it still wouldn't be easy. The first room was difficult: crying parents, distraught feelings, and pure agony. This poor family had justifiably lost all sense of control and hope in this moment. I expected more of the same as we approach the second room and I began to feel sick to my stomach. I'll never forget what this mother said, as tears slowly rolled down both parents' faces, "No matter what happens we'll get through it, day by day, as a family." Her calm manner instantly had an effect on myself and the entire team. How could she be so calm staring at the mountain in front of her? Didn't she know how her family and daughter's life was soon going to change? I spent the rest of that rotation and the many months since then thinking about the stark contrast I saw that day. The way we approach any patient interact can be reflected back at us. So as I continue to grow through medical school I strive to bring the calm demeanor of this mother to every encounter knowing that even the same diagnosis is never the exact same in two different patients. Now as I approach residency, I hope that when my time comes to care for patients on my own I will be ready to gently and meaningfully guide my patients through their disease while adapting to every individual I have the opportunity to care for.

New on the wards, I made my way to the room of my first patient whose complaint was shortness of breath. Your answers were short. You didn't make eye contact with me once. With a history of untreated HIV, you were diagnosed with a disseminated fungal infection. Day after day, you fought the wicked side effects of the systemic therapy you were on. I watched you battle depression and yearn for family, friends, and familiarity. No smiles. Why didn't they seek treatment sooner? Questions like this came up every day on rounds. Then the shortness of breath improved. Your mood perked up. You started gaining weight. I saw you smile for the first time. We started having daily conversations in the afternoon. You were homeless for a period of time after you learned of your HIV diagnosis. The medicines back that weren't nearly as easy to take daily. You battled addiction and depression and lost most of your family along the way. However, playing cards always made you feel at home. You would always find time to do that. On my last day of service, I came into your room with an Uno deck in my hands. The smile broke out on your face will forever be embroidered in my memory. It was during this last interaction that you told me you were ready to start taking your daily medications. I beamed with joy at the new-found responsibility you had taken in your health. With that, I told you it had been a pleasure taking of you and that I was so happy to see your improving health and your smile. As physicians, we can lose sight on why our patients don't take the appropriate steps to ensure their health. It's easy and takes very little time to project judgements on our patients. However, it's much more rewarding, enlightening, and compassionate when we take extra time to ask ourselves why our patients do what they do. With this little bit of extra time and effort, we are able to help our patients far beyond our clinic spaces or hospital rooms.

My 1st rotation as a third-year medical student was internal medicine, and as a neophyte clinician, I fast realized that the greatest thing that I could offer was my time, a realization which resulted in many long conversations with the patients on our service. And through one of these conversations, I found that despite his diagnoses of heart failure, renal failure, bilateral lower extremity lymphedema, and a non-healing foot ulcer, 60-year-old Mr. Roberts (pseudonym) was most bothered by rectal bleeding. We consulted gastroenterology, who suspected hemorrhoids, and from their note, I learned that: 1. A previous colonoscopy had failed to remove the entirety of a colonic polyp, 2. There were two endoscopic options – one would allow for polyp removal but not hemorrhoid banding, while the other would allow for hemorrhoid banding but not polyp removal – and 3. Gastroenterology had recommended polyp removal, to which Mr. Roberts had agreed. However, when I pre-rounded on him, Mr. Roberts was unaware that the procedure probably would not treat the bleeding. This experience taught me that our problem lists (i.e., with the residual polyp being most important) are often at odds with our patients' (i.e., with rectal bleeding being most important). I am in no position to judge the gastroenterology team for its decision, but ever since, I have tried to be more aware of how my problem lists align – or do not align – with my patients'.

When I was on my IM overnight call shift, I met a gentle, smiling elderly woman—Ms. D—who had been complaining of recent abdominal distress. A few days later, when I was back on the day shift, I saw that Ms. D was on our census with a small bowel obstruction. I requested to take her on as my patient, since we already knew each other. She had an extensive medical history but was always cheerful and brightened up when I came by to talk, even when my questions were painstaking and repetitive.

Over time, however, I found out that her family members weren't able to visit every day, so I started stopping by her room to chat every day after being dismissed, even after switching to other services. Even her family came to be familiar with me and was always appreciative that I came to visit when they couldn't

Several months later, I happened to hear two radiologists talking to each other about a patient that had experienced two major strokes in the past three days. I went over to learn about the case, but my heart sank when I saw the name on the CT—it was Ms. D

When I went to her room, Ms. D's daughter introduced me to the family members I hadn't yet met, and explained what had happened in the past few days. Ms. D could no longer eat or speak, was half paralyzed, and would rarely respond to stimuli. She offered me a seat next to Ms. D's bed; I sat there for a few minutes, held Ms. D's hand, and told her how much it had meant to me to be able to be a part of her life, and how glad I was to see her again. Until that moment, I hadn't known whether she was awake or blissfully unaware, but she gave my hand a long squeeze, and I squeezed back.

That squeeze meant everything to me. I realized how profoundly we had influenced each other's lives, and the invaluable power of human connection in medicine.

Some of my most impactful experiences with patients has been during my times volunteering at the free student outreach clinic. One poignant encounter I had was with a patient I met my second year, whom I'll call Caleb. Caleb, like many of the neighbors we treat was going through a harder season. He had bad glaucoma which caused him to go blind in his left eye and was going to cost him his right eye without intervention. He needed some glaucoma meds and possibly a surgery. It was his first time at the clinic and as a second year I was blessed to have more free time to talk with him and hear his story. It was so simple. He had a stable job in Illinois with insurance but made one bad choice which causes him to be in jail for a couple years. While in jail his left eye went blind and he was started on medicine which helped the right. When he got out he left his job to move to Indianapolis to be with his dying mother. Since he left his job, he lost his insurance. Now he can't afford the \$8 of medications he needs to prevent complete violence. What struck me was how similar we could be. One bad choice, one sick family member, one medical problem—and then I could be homeless and about to go blind. It was a less in the assumptions I make of patients. Caleb is a reminder that when a patient is late, or is not compliant, or makes some “unwise” choices in my eyes, to remember that I am only two steps away from poverty, or illness, or need of grace. All of us are—no matter how far we have come. So I need to keep humility and compassion while caring for future neighbors like Caleb.

Addendum: Caleb is doing well on his medications as of March 2020 and got a new job and a PCP through Eskenazi.