

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.

Students were asked to respond to the following prompt:

Please describe a patient (or patient's family) experience you witnessed that inspired you or taught you an important lesson as a developing physician.

Aaron Gilani

As I approach the end of my third year of medical school, I have begun to reflect on all this journey has meant to me thus far. An experience with one of my patients and her family on the Cardiothoracic Surgery team at Riley is one that I will carry along with me for the rest of my medical career. I was introduced to a newborn who needed heart surgery, but I was also met by a family not originally from the United States whose eyes evoked fear and uncertainty about what this would mean for their newborn baby.

It brought me back to my parents coming to America with my 24-week-old brother, Aashish, who is also deaf and blind. They came to a new country without knowing anyone, what was wrong with their child, or any knowledge of American healthcare. Though my brother is older than me, meeting this family was everything I imagined that my own parents faced in 1988. As a medical student, I pondered about ways I could help them outside of things like checking on them often, providing updates, and giving that extra "is there anything else I can help answer?" just in case they were afraid to ask earlier.

I remember my parents telling me how they don't just remember the wonderful doctors/nurses my brother had, but how the entire team helped them feel comfortable: the information desk associate, the custodians, the parking garage team, etc. I felt coming face to face with the patient and her family was destiny in that I had an opportunity to help pay it forward for the care my brother received. It was my duty to ensure they were getting proper support from social work and were able to get to and from the hospital without difficulty. The best part of my interaction with the patient and her family was that I was able to later see them in clinic while on another rotation. Despite being the medical student, I feel as though they were able to confide in me and trust me to help take care of their daughter.

Aida Haddad

It is a sunny afternoon on the trauma service. While finishing notes, we are paged for my first level 1 trauma: a man on dual antiplatelet therapy had syncope and fell from standing at work; he has a posterior scalp laceration and possible loss of consciousness. We arrive at the trauma bay and don PPE. Once EMS arrives with the patient, the primary survey begins. I watch as the team asks John his name and learn that he has type II diabetes mellitus--that he had not eaten since last night because he almost missed the bus this morning, and breakfast wasn't an option. John is in a cervical collar, calmly answering questions while staring at the ceiling. His clothes are being cut off and physicians report findings while nurses secure peripheral IV access and take vitals. I get a warm blanket to make up for the layers of clothes he loses in the assessment. A normal head CT scan rules out hematoma; he is then returned to the trauma bay while providers finish documentation. Until this moment, I have been a peripheral observer of this patient encounter. Now that he is deemed stable, it's just John and me. I crane my face into his field of vision, saying, "Hi John. My name is Aida, and I'm a medical student. How are you doing?" John replies, "Hi," as his eyes form tears. His voice cracks, "God, how did I end up here today?" This moment embodies my most valuable clinical lesson to date--that as a physician, I will see some of my patients on their worst days. And when the dust settles, it will be within my power to provide comfort once John has a moment to realize that skipping breakfast wasn't the only thing that went wrong today. I take a breath, and then gently rest my hand on his shoulder, "I'm so sorry. What can I do for you? Who can I call for you?"

Alaina Turchi

An important lesson that I have learned is that patients are people who often need patience, especially from their medical team. I had one of my most impactful experiences during my pediatric clerkship. My patient had cystic fibrosis, which would land him in the hospital multiple times a year. One of the most important aspects of humanism that I learned did not come from understanding the challenges of low SES status, social barriers, or adolescent health, but from challenges in maintaining healthy relationships, especially the parent-child relationship.

Through my conversations with my patient's mother, I learned that she struggled deeply with how to be a parent/rule enforcer because it resulted in not always being well-liked and received by her child. This ultimately was the root of many pediatric hospital stays as she did not like enforcing medication adherence. Instead, she opted for what she believed was giving her son independence, by allowing him to be in charge of his medications. Giving her 12-year-old son the burden of organizing and administering his many medications not only led to hospitalizations but also extreme stress on his part. Due to the many hospitalizations, and CF exacerbations, our patient was not frequently attending school and had difficulty making friends as he was rarely present. This further intensified his mom's pressure to be a friend. They are the only two members of their household, and she feared of becoming estranged as many other family members had. I can recall her telling me that she felt as if her time with her child was limited and she didn't want to taint what little time she perceived she had with enforcing rules. I learned that something that our team had once perceived as irresponsible parenting, now had deeper meaning and created a further understanding of the emotional struggle this family faced.

Alejandro Enrique Bolivar Gorrin

During my Ophthalmology rotation, I saw a patient with a herpes zoster infection on her eye. She could not see anything on that side and was in an immense amount of pain due to the infection. She had also been diagnosed with end-stage bladder cancer and was given less than a year to live. Even though there was not much we could do for her vision, my attending decided to perform a small surgery so she could at least be comfortable during her last months of life. During pre-op, while my attending was signing paperwork, I approached the patient to ask how she was feeling. She said that she had been suffering enough and she did not want to suffer anymore. She told me how lonely she was and her fears of dying alone. I held her hand and listened. I told her that our goal was to make her as comfortable as possible and that she was in the best hands. While shedding a tear, she simply nodded and closed her eyes, squeezing my hand tighter. Once the surgery was over, I went back to check on her. After a quick post-op assessment, I asked what her plans were once discharged. She responded that she was just going to go home and watch TV. We chatted for a while about our favorite TV shows, bonding over our love for Jeopardy. Before I left, she held my hand and said, "thank you for being here with me." That statement absolutely broke my heart. I could feel her pain and, at the same time, her gratitude. As a medical student, I did little to help her in terms of the actual procedure, yet I was able to make an impact in other ways.

She reminded me why I decided to pursue medicine. The relationships and connections that are made through medicine are incredibly meaningful and everlasting. Sometimes the best medicine is given via sitting in a chair and listening quietly to the patient. The results of therapeutic interventions will vary, but our efforts and compassion are what patients remember the most.

Annie Stenfenagel

It's hard to be in 8th grade and still wet the bed. It's frustrating when you feel like you have tried everything-- water restriction, bed alarm, bladder training, etc-- and nothing seems to help. And then, a solution. A simple procedure, one the surgeon has performed hundreds, if not thousands of times. About a week of ice cream, applesauce, and rest and "voila!" problem solved. Of course they tell you about the complications, a laundry list rattled off with the assuring, "___side effect___ is very rare. I don't anticipate any of these issues with ___patient name___." It's also natural as a parent to blame yourself with something goes wrong. "He didn't want the procedure..." she said, feeling as though her decision to proceed made her automatically guilty for the rare complication that followed. He's a typical 13-year-old, into football and video games. He is no longer a typical 13-year-old. Typical 13-year-olds don't have strokes. T has barely spoken since his surgery, first because of the pain and now likely because of the trauma. His mother hasn't left his side. T's post op pain led to dehydration, and the dehydration led to a cerebral sinus thrombosis, and the thrombus led to a large stroke. It's a nightmare situation for any parent, but Mom has remained strong and has been his advocate and voice throughout this scary time. At home she also has two other daughters who are unable to be with their brother due to the visitation restrictions. T is recovering, and Mom has begun looking to the future and has done perhaps the hardest part, asking for help. "What will be his new normal?", "Where do we go from here?" "I thought I would be able to afford Christmas gifts this year!" There are a lot of unknowns for T and his mom right now, but they are learning to take life one day, one step, at a time.

Colton Junod

This patient story was an experience I had during my trauma surgery rotation at a community hospital. A young patient was brought in by EMS for a self-inflicted gunshot wound. The patient was found by their parents who quickly called for help. When EMS arrived with the patient, everyone in the resuscitation room knew the outcome was going to be very grim; however, everyone still sprung into action. After some interventions were performed, the parents quickly informed us that their child would want their organs donated. As a student, I was a little shocked they had already realized how unlikely a positive outcome would be without the medical team explaining the gravity of the situation to them. The patient was stabilized and transferred to the ICU.

While in the ICU, I had the extraordinary opportunity to be present for some of the most powerful and meaningful conversations. The parents, nurse, and physician all talked about the child's prognosis and the organ donation process. This was extremely emotional not only for the parents, but also the nurse and physician who had children around the same age as the patient. This interaction was the first time that I can recall seeing the medical team's emotions be a part of a patient case. Usually in medicine we attempt to be stoic and hide our emotions from the patient. However, in this case I could really feel that the patient's parents appreciated the involvement of the nurse and physician's emotional connection to their situation. It made the conversation meaningful and powerful during this tragic time.

I feel very fortunate to have witnessed this case and interaction because it is something I would have never learned from reading a textbook or during an OSCE. In the future I will be more apt to show emotion, empathy, and humanity during an unfortunate situation as the one I described. The humanism and love displayed by the medical team in this case will be something I never forget throughout the rest of my medical journey.

David Huston

"Douchebag"

Trailing behind, head bent and scribing away as I pushed a WOW down an ED hallway back to the bullpen, my doctor decreed what he made of a 22-year-old man with infective endocarditis and a homemade swastika tattoo on his thigh. At the moment I completely agreed, though I lacked the confidence to say it aloud.

His personal judgement didn't make it into my transcription, but I got the feeling the doctor's disdain had been communicated to the patient nonetheless. I often think back to this young guy. He had skipped his scheduled valve repair surgery. His blood pressure was high. His vegetations were large. He was frail. His UDS was nearly pan-positive. He had just jumped out of a second story window to evade someone. He was eating a large bag of Lay's. He was a mess.

However horrible his hate, however pathetic his situation, however little regard he had for himself and others, he was and is a child of God. A person worthy of respect, regardless of how little he dished it out. He needed compassion, not contempt. Help, not disregard. He had been and probably would be noncompliant with care. Results matter. But so does the way we get there. Life isn't just a destination, especially for someone with such a bumpy road.

It's often too easy to think down on others. It makes us feel superior. Makes us feel the power that comes with the judgment of deciding who is and isn't worthy of our compassion. It becomes a talking point, a source of superficial bonding with coworkers, creating an us-vs-them group mentality. Falling into this trap challenges our ideals, ultimately bringing us down too, taking the joy out of service.

I learned that it isn't always easy to be compassionate. I'm ashamed to admit, but for this patient and others, it takes effortful introspection to check my worst gut knee-jerk reflexes. Mindfulness to make the conscious decision to hang onto humility. And intentionality to connect and try to serve patients as best I can where they are, especially when they are tough to love.

Emma Eckrote

I have been incredibly fortunate to meet kind patients and devoted families on the wards. My most meaningful experiences came from my time with a bright and smiling first grader. She was a curious, outgoing girl hospitalized for a facial abscess. Her day of admission was my first day on the rotation, and we became fast pals. By day two of her stay, she was bored. No amount of art or music therapy could keep her entertained! I fell into the habit of popping up to her room for a few games of UNO each day after I finished my notes. I enjoyed listening to her tales of her siblings, parents, friends at school, and her imaginary pet dog, named Ivan, while she played Draw 4 card after Draw 4. She told me of her dreams to be an artist, or a ninja, or maybe a teacher, or possibly all three. Her mom always welcomed me in the afternoon too, and we spoke at length about her other 2 children at home, her close-knit Burmese family, and her concerns with the financial stressors of the 8-day hospital stay. I felt incredibly fortunate to be welcomed into their space each afternoon, invited into their lives, and trusted with such sensitive and important topics. At the end of her stay, I was gifted a colorful and elaborately folded Thank You drawing of the two of us playing Uno. Her mom thanked me for my time and willingness to get to know them as they were outside of the hospital, not just as a sick child and a worried mother. I keep this drawing framed on my desk as a reminder each evening as I study. The connections we make with our patients can be so meaningful if we take the time to know the person, rather than just the ailment. I now strive to know all my patients a bit better, taking time to ask about their families and hobbies and values, working to form a relationship beyond their diagnoses- taking time to treat the person.

Emma Ross

I never knew my first patient's name, never took her history, never saw her alive. I met her on the first day of anatomy lab during first year. In April of that year my best friend passed suddenly from hypertrophic cardiomyopathy. Four years earlier, my sister passed in a tragic car accident. I knew death way too well. I'd like to say I was strong. I wasn't.

I remember uncovering my patient for the first time, hands shaking, tears in my eyes. When I uncovered her, I was surprised to see how beautiful she was. She was only 40 and had died of metastatic breast cancer. I struggled all semester, picturing her as someone's best friend or sister, imagined others doing to my passed loved ones' bodies what I was expected to do to hers. I knew she chose this, but it didn't feel right. I had panic attacks every day.

After the memorial ceremony we had for the donors and their families, I was chatting with some classmates. A woman approached us; she asked if we knew who had her dad. She was proud of her father's sacrifice and wanted to know what we had learned from his body. That moment touched me deeply. Although this wasn't my patient's family, I like to think they were in that room with me that day. I know her family was proud of her sacrifice too, and grateful that the knowledge gained from her body would live on in the minds of future physicians. My time in anatomy lab inspired me to treat each patient with the utmost respect and admiration, showed me how beautifully complex and special the human body is, and fostered within me an even deeper love for medicine. I'm inspired by my patient's truly selfless act to give her body to the education of others. I will never stop trying to pay it forward as I work to heal all of my current and future patients.

Eric Aksu

At the Student Outreach Clinic, it is easy to despair at the long list of challenges facing any given patient. Mr. Cory (name has been changed) is one such patient. Mr. Cory often comes into the clinic intoxicated after having spent one or several nights sleeping in the open air. He receives medications and care at the clinic for several chronic conditions, though it is sometimes unclear to what extent the care we give is improving his wellbeing. Frequently, months will pass without seeing him until he comes for treatment of wounds or an infection that he incurred in his difficult day-to-day life. One of the first times I witnessed his care at the clinic, he was having a corn excised by one of the clinic team working that day. I can remember him moaning and crying out while the provider did their work slowly and carefully. After his feet were washed and bandaged, he put on a pair of dry socks, slipped into his broken shoes, tearfully thanked the person who had treated him, and was on his way. The provider addressed him attentively and put his hand on his shoulder as they spoke.

It is important, in my mind, to approach patient care with humility. Our patients spend most of their lives away from our care. Our power as individuals to affect their fortunes can be quite small. We can't neglect the important work of improving the world we and our patients live in; evidence has shown that time and resources spent in this regard can have a much larger effect than many of the things we attempt within the walls of clinics or hospitals. At the same time, in our short moments together, the care and attention we can give to our patients, even if it only addresses one small issue in a long list, can make a real difference in their existence. It is a real privilege to be invited by those we care for to serve in these small moments.

Ian Oechsle

During my first week of Psychiatry, I took a history for a new admit: a 36 year-old male with paranoid schizophrenia who was found wandering the streets of South Bend. I approached as he paced in the corner of the foyer and asked him to come speak with me. His speech was 50% incomprehensible and he would frequently become agitated from my clarifying questions. This began the journey of trying to decipher this man's life and parse out fact from fiction. But I persisted

and spent three separate mornings with him. The social worker had informed me that this man was institutionalized after 6 years at state hospital and delusional--fixated on the belief that everyone wanted to "put him to sleep" and that nothing useful could come from his interview. Perhaps it is my youthful ignorance that pushes me to deny such a statement, but I entered the conversation cautious yet hopeful to understand who he was.

Our conversation seemed to go in circles for hours as I tried to get a sense of his past and overall perception of the world. He complained incessantly about "how useless" it was to talk about his life and how I could never help, but every time I would look at him square in the face and tell him, "in this moment I care for you because your life matters and you are unique as we all are." I often replay the conversation in my head because it is tough for me to never know whether anything I said was internalized. However, I vividly recall the look he gave me when I stretched out my hand to shake his--as though this small gesture was the first kindness he had received in his life, and his entire expression shifted for that moment. The lesson for me was simple but painfully important: no matter the popular opinion, the time, the situation, or the history, there is always an opportunity for a meaningful encounter with another in which there is a shared reminder of the unequivocal sacredness of human life.

Kate Harris

One morning on rounds with the cardiac surgery team, we visited Mr. M, who had just undergone his second open-heart surgery in the past decade. He had traveled from a different state and tearfully told the team he was feeling quite overwhelmed without his family here. The attending offered brief words of encouragement, but we quickly moved on to the next patient. I looked back at Mr. M -- alone, his head hanging low. I felt for him. I glanced at his name on the list and thought, 'With a name like this, he has to be German.' I studied German in school, so I was attuned to German names. I vowed I would dust off my second language and visit him after rounds.

When rounds concluded, I went to his room and introduced myself. I told him I had taken German in school and could not help but notice his name. "Are you German, by chance?" I asked. His eyes suddenly brightened, and a large grin stretched across his face as he nodded. He proceeded to tell me he had been born in a small town in Germany but moved to the US when he was a young boy. He spoke about trips he had taken to visit family still living there. I shared that I had lived in Nuremberg for a month. We bantered in German and chuckled when the nurse gave us a confused look. Mr. M's demeanor had completely changed. And each morning thereafter, he would always greet me with a big smile and a "Guten Morgen," and share another memory or picture from Germany.

My interaction with Mr. M emphasized the importance of reaching out to patients, especially when they are feeling alone. A single conversation about life or travels can be enough to transport a patient's mind to a happier place. Taking a moment to visit with a patient can be enough to help them relax, smile, and feel less alone.

Luke Richardson

Mr. P was a patient of mine for the last week of my Psychiatry rotation at the VA. He was transferred here after his neighbor who helped out at home had noticed that Mr. P had become quite a bit more forgetful and paranoid in recent weeks. On his first day, he seemed hazy, confused, and unable to give much detail about what had been going on. He was very apologetic, thinking he had done something wrong and was in prison. We thought over the course of a few days he might regain some clarity and be able to tell us more.

He never did. Each day was like starting again, reacquainting myself with Mr. P and he with me, always very glad to have a new face to talk to. I noticed through our meandering conversations, however, that I began to understand Mr. P in a deeper, unarticulated way. He had an essence that had remained untouched - this was a good, kind man. When his thoughts fell out of order, he always anchored back to

the two things he loved most – his son’s family and his dogs. He was always thankful, even when he wasn’t sure what for. I looked forward to meeting him again each day.

Mr. P eventually left to live with his son’s family while they looked for long-term care. I still think about Mr. P, and how, despite having lost so much of what he may have thought of as “himself”, the truly valuable parts of his character remained intact. As a physician, husband, father, and friend, it is unlikely that I will be able to control much of the course my life will take. I may, like Mr. P., forget much about my life and the things I’ve done. However, I can choose kindness, patience, and compassion on a daily basis to cultivate a legacy that will outlast anything else I may achieve. Knowing Mr. P inspires me to remember that the things I do are of little value if they are not done in love.

Maria Khan

I once had a patient with a brain tumor that resulted in hypopituitarism. Her father was a single parent and felt that the mom’s home was not a safe environment for his daughter. Because he worked contract jobs, he was not able to get FMLA when his daughter was admitted for days/weeks, resulting in him repeatedly losing his job. Because of his precarious financial situation, our teams had consulted social work who then called DCS. This process frustrated the dad a lot, who felt like when he “reached out for help” he was instead trapped and “almost had his daughter taken away.” On the other side, the healthcare team was extremely distrustful of the father outside the room—they felt he was not recognizing the severity of his daughter’s disease, not prioritizing his daughter’s sickness, and not working with the team. However, in my time with this family, it was evident that the dad loved and took care of his daughter. Because of electrolyte abnormalities are difficult to comprehend and not immediately symptomatic, he was not always able to recognize when she was very sick and did not have access to transportation to readily bring her to the hospital.

As a medical student witnessing both sides of this, I learned how important it is to step into the family’s shoes and understand the way medical process can appear to them. As physicians, it will be easy to assume that our priorities are paramount: the most evidence based treatment plan for our patient is the most important next step. But a patient/family who does not agree or fully understand our perception is not immediately an irresponsible parent or noncompliant; it is likely their complex lives outside hospital walls that make their priority list very different.

For this family, abnormal electrolytes can be a life-threatening emergency that is corrected with hospitalization. However, to provide long-term compassionate care, we must partner with the family and build mutual trust by understanding their unique life perspective and priorities. Only then can we bridge our priorities together to care for the patient’s health and overall well being comprehensively.

McKenzie Barber

Walking into our patient’s room on the labor and delivery floor behind my chief resident, I was holding my breath. We were going to talk to our patient and her partner about her induction of labor, which is usually an exciting discussion about how soon the parents will be meeting their new baby. In this case, our patient was being induced at 20 weeks after her anatomy ultrasound revealed her fetus had anencephaly. During my one week of labor and delivery, three of our patients gave birth to babies with anencephaly and each discussion was as heartbreaking as the last. Instead of nervous smiles on the faces of these patients and their partners, there were only downcast eyes and grief-stricken tears. There were many days during my OB/GYN rotation when I questioned if I would be strong enough to pursue a career filled with such difficult situations or if I would be able to compartmentalize the grief of one patient in order to celebrate with the next. However, as the week progressed, it became clear that great physicians are not those who separate themselves from their patients’

hardships, rather they are the physicians who sit beside their patients during their most difficult days and feel privileged to do so.

As busy as our service was that week, my chief resident sat with each patient and allowed them as much time as they needed to express their feelings and ask questions. Throughout each delivery, she ensured they were always comfortable with the plan and felt like they were making the right decisions for their family.

Not only was this empathy and grace offered to our patients, it was also afforded to each team member assisting in the deliveries. We were each encouraged to take opportunities to care for our own mental wellbeing and process our own feelings about these deliveries. My chief resident truly emulated the type of physician leader I hope to become. As I look forward to a career in OB/GYN, I will strive to approach each patient and team member with the same empathy that was afforded to me.

Michael Harding

In November, I was working with the Palliative Care team at the VA hospital, COVID-19 cases were peaking, and strict visitation policies were weighing heavily on both families and providers alike. The Palliative Care team had discussed how the situation was providing additional barriers to care as numerous facilities were denying new patients and family visitation in the final days of a patient’s life were being severely reduced. These experiences provided emotional strain and left all involved with too few choices at such a vulnerable time. The team would spend additional time working to coordinate with social work and sometimes using software on their own phone to videocall with patient’s loved ones while in the patient’s room. It struck me as an added component of patient care that I hadn’t seen with such emphasis. They provided time for the patient and their family to visit for a bit before also discussing the patient’s status. I learned how important it is for patients to have access to their social support, especially for those approaching the end of their life. This pandemic has highlighted the importance of social support circles and human interaction. I better understood the power of time spent in patient encounters. I was able to incorporate this in my subsequent clinical rotations where I could round on my patients and make sure to ask if they had been able to communicate and call their family since visitation was limited. I would work on arranging time for virtual visitation and socialization if they were unable to do so themselves. I hope to incorporate this practice into my future medical career. The patients were always grateful, and I learned a more holistic view of patient care and needs. I believe this approach to bedside doctoring emphasizes the multifaceted dimensions of patient health and provides a deeper bond with the patient and more opportunities to listen.

Mikayla Burrell

The most impactful experience to my development as a future physician thus far has been the month I spent on the heme-onc inpatient service. These patients helped me grow to further appreciate the undeniable value of taking the time to get to know each patient and their hopes, goals, and fears. I learned these lessons through the stark contrast between two different physicians (who I will refer to as Dr. A and Dr. B) and their treatment of the same patients.

During rounds with Dr. A, the entire team filed into the rooms of every single patient, and everyone sat down. We asked each patient, “What’s on your mind today?” and “What are you worried about?” I learned more about what was happening with each patient, both medically and emotionally, during this time than I ever had before during rounds.

Dr. B treated his rounds very differently, which is best exemplified through a particular patient interaction. The team had just learned that this patient had an aggressive form of leukemia. Dr. B proceeded to walk into the room, stood behind the patient with his stethoscope ear tips already plugging both ears, placed the diaphragm on the patient’s back, and said to the patient, “You have leukemia, and you start chemo today.” Dr. B then turned around and walked out of the room, without so much as a glance into the eyes of the patient. This

“breaking of bad news” was gut-wrenching. The fear in the patient’s eyes was unmistakable and one that I will never forget.

While this question is asking about a specific patient, I feel that my most authentic answer lies in the comparison of my patient interactions between these two physicians. I vowed to myself and my future patients that I would strive to be more like Dr. A. I decided that I would always take the time to sit down, look into the eyes of my patients, and honestly listen to them while providing any care— whether that be delivering bad news, discussing a complicated treatment regimen, or simply asking what is on their minds.

Natalie Campbell

I had the opportunity to take care of a 78-year-old female presenting with a “bump on [her] pelvic area that has been growing for quite some time” while rotating in a GYN clinic. I could sense right away she seemed emotional, so instead of running through my illness script, I asked how she was feeling in that moment. She took a second, sniffled, and started explaining that she was embarrassed for not getting her condition checked out sooner, as it was something she had been putting off for years. I could tell this was really weighing on her, so I told her that she should not be embarrassed for waiting, instead she should be proud that she was brave enough to come to this appointment. I told her she took the first step in showing up to the appointment, and together we can take the next steps in figuring out what is going on and how to manage it. She smiled at me and said that she would like that very much.

Through this interaction, I learned how important it is to listen to the patient, not just hear what they have to say, but take the time to learn what their concerns are beyond their medical condition. From my clinical experience thus far, I have realized that sometimes all a patient needs is someone to listen to them and empathize with their story. A patient being heard by a provider can sometimes be more valuable than a quick diagnosis and treatment plan. Reflecting on this experience, I now see that the art of medicine is not only applicable to management of medical conditions, but also the art of interpersonal skills to address human needs as well.

Sara Garcia-Dehbozorgi

It was my first week of inpatient medicine at the VA when I met Anne. Prior to meeting her, I read through notes to gain a better understanding of her social history and barriers to care. In her chart, she was identified as a male veteran who had a chronic history of loss to follow-up due to social and economic factors. I began to notice the discrepancies in language when others were referring to Anne; some documented her name as Anne while others used her legal name with the pronouns “he, him, his”.

Upon entering her room, I was greeted by someone who was very skeptical of my presence and seemed hesitant to speak with me. After introducing myself, I asked her name and gender pronouns. Her face showed an immediate sense of relief when she heard those words. She then relaxed her posture and began to share her story. Her previous notes described a patient who was difficult to work with and who often rejected physician recommendations. When my team met with her, this was clearly a patient who lacked an ally in the healthcare field. Every morning I learned more about her and she shared fond memories of cooking as a chef in the army as well as the difficult memories of her history of domestic and verbal abuse from her ex-partner and father.

Anne shared with me the struggles she has faced as a member of the LGBTQ+ community with securing jobs and social support free of judgment. It was clear that her sexual and gender identity had affected her ability to properly address her healthcare needs. This patient experience highlights the importance of valuing a patient’s identity when handling their care. By valuing a patient’s identity and gaining their trust, a better relationship is made between physician and patient. To properly address the needs of the LGBTQ+ community and other underserved populations, we as leaders in the healthcare community need to advocate for our patients and it can

start with a change as simple as valuing a patient’s true identity.

Sarah Swiezy

My first week at Riley, we had three admissions for new-onset Type 1 Diabetes (T1DM). These kiddos get a standard two days of intensive diabetes classes. All three were 8-12yo, Caucasian, and had both mom and dad actively present.

My second week, I got an admission for T1DM. This kiddo was 11yo, Hispanic, and only mom was present at bedside. When I met them, mom and daughter were speaking English. I explained the plan for their stay and sent them to class with the diabetes educator.

Later, the educator called to express concerns. During class, mom politely refused to do insulin calculations; daughter was doing okay but would need support. Dad never showed for education. Mom left the hospital as soon as class was over, and did not plan to return until tomorrow morning, meaning she would miss practicing insulin calculations during lunch and dinner. We both felt frustrated: why don’t these parents care about their daughters’ lifelong diagnosis?

The next (last) day of education, still no dad. Mom again refused to do insulin math, and daughter was getting visibly frustrated. As a last effort to explain the importance of the in hospital education, I brought my Spanish-speaking colleague with me. As soon as he started speaking in Spanish, mom broke down. She was overwhelmed. English is not her first language, and she’s never done math in English. She didn’t want to bother us by asking for an interpreter. Dad works six days a week and his off-day is Sunday. Mom has five other young children and can’t leave them alone for long.

Thankfully, it was lunch time; we stayed to help—in Spanish—with insulin calculations for the meal. Mom caught on immediately and did dinner calculations totally independently. We extended their stay one more day, until Sunday, so dad could also learn. When the family left, they were just—if not more—competent than any other family.

I learned 1) never assume someone else’s situation, language preference, emotions, or capability and 2) leaning in to implicit biases without the whole story always leads to inadequate and insensitive patient care.

Sean Buehler

I had the privilege to help treat several of our clients from the Shalom Community Center while on clinical rotations, and each one further reinforces my belief that a physician who is involved in the community is better ready to serve the needs of their patients. One patient in particular, M, was a longtime guest of our day shelter who was admitted for severe cellulitis and sepsis. She became very ill and not able to communicate and was transferred to hospice where she passed peacefully. It rocked me to hear news of her passing, especially after she had just obtained housing for the first time. For years, she was treated poorly by practitioners because she was seen as a “frequent flyer” for her alcoholism. Apparently, she had been dealing with her infection for some time but had foregone a visit to the hospital because “no one ever helps (her) there” It pains me to think that had she received more compassionate care throughout the years, she may have caught her infection sooner and avoided an untimely death.

Her Husband, J, was also a longstanding member of our unhoused community – known and loved by many. He was unable to see M before her passing due to a short stint in prison, and it tore his heart apart. He was well-known to providers at the hospital and especially in the ED. On Christmas Eve of 2020, he was found dead on a park bench not two blocks from the hospital, frozen to death. According to the reports, police officers performed a subpar well check on him that morning, overlooking obvious signs of hypothermia because J denied help, stating that he “gets treated bad at the ER”. I was working a shift in the ED the day he passed, and overhead staff cracking jokes about his passing, like whether or not he and M were “in heaven or hell.”

These experiences showed me that we need a revolution of compassion in medicine. We cannot understand the struggles of every

patient, and we need to treat everyone like we would our own family.

Shannon Jager

I don't know if he could see me. I don't know if he ever saw the goofy grimaces that I made to try to make him laugh, with his head nestled safely in the crook of my arm. Physiologically, I knew the odds were poor: his ammonia levels, severely elevated due to an uncontrolled metabolic disorder, had caused catastrophic cerebral edema and atrophied any cortical tissue that could process vision. I followed Oliver's case for three weeks during my time with the inpatient developmental pediatrics team. Someone had left him outside of a fire station after his birth, and he had spent the majority of his three-month lifetime in the hospital. He didn't have any visitors, so I made sure to spend my free moments with him: holding him and singing little songs to him. Every time he was ready to be discharged, his ammonia levels would spike, and he would have to stay. The team joked that he'd grown attached to me and didn't want to leave the hospital while I was there.

On November 16, I entered the inpatient team room at 6:45AM, like I always did. A resident, already seated in front of a computer, looked at me with kind eyes: "Oliver passed last night." I froze – the rest of the day passed within a hazy, drowning fog. Only once I was seated in the solitude of my car did fragmented sobs tumble forth, and I felt the heavy, visceral ache of loss. I called my best friend and attempted to articulate my thoughts. I was horrified by what little we had done for him, even though I knew there was nothing else medically that could have helped him. "You loved him, Shannon. You showed him love every day. That is not nothing."

Oliver taught me a profound lesson. Patients for whom nothing can be done medically can be easy to remove from the ever-lengthy to-do list. My experience with Oliver taught me that there is never 'nothing' to be done – you can always show love. You always have the opportunity to offer kind words, to sit in silence with someone who is grieving, or listen to those who are struggling. Oliver taught me that even when my medical knowledge cannot cure, my job is not over: I can always offer my compassion.

*Names have been changed for privacy

Taylor Zike

While rounding at Riley, I met a dreary young boy with a recent brain tumor resection. Seeing his despair, I got down to his level, introduced myself, and asked what he wanted to be when he grew up. With his innocent stare and gentle voice, he responded, "A scientist." After hearing this, I told him that I'd have an exciting scientific experiment for him the next day and that I'd be his scientific assistant. This is when I saw him smile for the first time, as he said, "cool," and gave me a fist bump.

That night, after having him choose a few experiments on Sciencebob.com, I scrambled to gather the scientific ingredients. The next day, I couldn't help but grin from ear-to-ear as I approached him with our ingredients. He was bopping up-and-down from his wheelchair, yelling, "My assistant is here with our experiments!" While incorporating the experiments into his Physical Therapy, having him stand and maintain balance when pouring/mixing ingredients, his joy and excitement were contagious. After the experiments, I asked him if he'd be interested in doing a "Science Show" for the whole team, including his family, and fellow Riley heroes. He ecstatically replied, "Yes, but I will need my assistant!" His response melted my heart, and I told him that I wouldn't miss it for the world.

Over the next few days, we prepared by performing as many experiments as we could manage and were even nicknamed: "The Mad Scientist" and "Lovely Assistant." His will-power, work ethic, and joy were truly inspirational and led to the most spectacular "Science Show" that I'll ever be a part of. Our team had so much fun. Witnessing his dramatic improvement and his pure joy, allowed for a life changing and unforgettable experience, while confirming my passion for medicine.

On his last day, after a surprise "VIP Science Show" by Rick

Crosslin, it was time to say goodbye to my PIC (Partner In Creativity). I had to fight the tears, because I knew I was going to miss my little hero. To my relief, as he gave me one last big hug, he reassured me that he would be back to visit Riley one day and that he would need his assistant when he did.

Tianna Vander Missen

It was day 3 of his hospital admission for severe infection of a peritoneal dialysis site and he was faced with news that he would transition to outpatient hemodialysis. His care included more than five teams and he was utterly overwhelmed. Between the renal, infectious disease, internal medicine and other teams each telling him different plans, I could barely keep track of his care, let alone a very ill patient. To him, it felt like each team was operating on their own terms without a cohesive plan. One morning, during my pre-rounding, I sat in his room and just listened. He had many concerns and felt like he could not make decisions about his care; I answered as many questions as he had. By the end of the conversation, you could see the gratitude in his eyes. He told me "I feel like no one is keeping me in the loop." After hearing that, I did my best to ensure he was "in the loop."

As the medical student on his internal medicine team, I was in a unique position because I had more time than other staff and could coordinate with all teams. As each team made changes to his care, I made sure to relay him updates face-to-face, even if it meant taking several flights of stairs. After many encounters, he began to take control of his care, making decisions he could not possibly have made before. One day, I swung open his door and he jovially said "what good news do you have for me? You're the good news girl!" I could not help but smile.

During his operation, I called his family to update them. They knew about my role in his care and thanked me for turning him into the captain of his stay. In these moments, I realized the importance of remembering the human behind the notes. These are not clinical vignettes we treat, but patients with fears, hopes, families, and the desire to be cared for. The care our patients receive completely transforms when we take time to meet our patients as humans.

Anonymous 1

Before I met CD, the physical exam was my awkward pre-rounding ritual; early in my third year, I was just finding my flow examining from head to toe. CD was a young man who was incarcerated and had active tuberculosis. He was thought to have new bacterial endocarditis likely transmitted through IV heroin use. CD was my first patient who was incarcerated and the first requiring me to don the omnipresent yellow gown and N95. I was only becoming accustomed to seeing patients in their hospital beds, so seeing his ankles in silver cuffs attached to the bed was admittedly disturbing. Left without my trusted MDCalc, I remembered that bacterial endocarditis could present with Roth spots, Janeway lesions, Osler nodes. But that was the textbook, not the man in front of me. CD was clearly uncomfortable: diaphoretic, feverish, unable to move his ankles, with goosebumps and dilated pupils as the first signs of withdrawal, repeating that he wanted to leave the hospital. After interviewing him, I started my head-to-toe ritual. As I examined his bare feet immobilized by cuffs, I palpated each toe one-by-one searching for the textbook signs. At his left fourth toe, CD withdrew in pain. I felt foolish sharing this finding on rounds, but my intern, senior resident, and attending all paused when I said this. I was only one to examine his left fourth toe that day. One day and MRI later, and my attending shared that I had caught osteomyelitis at an early stage, potentially sparing CD significant morbidity on top of his preexisting infections. This interaction prompted me to reflect on how the sanctity of the physical exam, as old school as it gets, should never be lost – especially for a patient subjected to multiple levels of societal stigma in being incarcerated, having a substance use disorder and an airborne infection, as well as being a person of color. CD was not a case in a textbook; he was a man who deserved equitable care from

which I am grateful to have learned a lesson in the earliest days of my career.

Anonymous 2

A recent interaction taught me an important lesson regarding a health care provider's role. I was working with a cardiologist and went to see a patient who is being treated for alcohol-induced cardiomyopathy. He is maximized on all heart failure medical therapy with only minimal improvement in his ejection fraction and symptoms. He continues to drink heavily and was adamant that he did not have intentions on stopping, even if alcohol-related complications ultimately ended his life.

Initially, I was struck by this and began thinking about how I could convince him that alcohol cessation would improve his life and his overall health. However, instead of jumping to that process, I chose to explore what his barriers to quitting were. He has chronic back pain and said that a few beers helped "calm his nerves." He also said "it's just a habit I'm not willing to give up." We discussed alternative options to manage his pain, reviewed the negative effects of alcohol on his health, the benefits of alcohol cessation, and programs available to help, but his mind remained unchanged. As a result, the conversation shifted from alcohol cessation to how we can best support him given his decision to continue drinking.

This support, of course includes sharing our medical expertise and recommendations, but also being understanding of the patients' circumstances, respecting their decisions, and not letting that interfere with your compassion towards them. I think in medicine, we tend to conceptualize healing as identifying problems (disease) and fixing them (treatment) to return to an ideal state of health. While this is an important part of what health care providers do, this patient reminded me that the provider's role is not limited to sharing knowledge and making recommendations. We also have the opportunity to be an ally for the patient through listening. In seeking to understand our patients better, we provide them with better care. As a physician, not only do we heal by caring for the patient, but also by caring about the patient.

Anonymous 3

When I was on service for pediatric plastic surgery, we had a teenage patient who had been through significant trauma from a car accident leading to multiple surgeries and lifelong debilitating injuries. The plastic surgery attending I was with was assessing her hand nerve injury. Instead of starting the conversation with talking about the patient's hand, he said to her "You have been going through a lot lately. How have you been doing with everything?" I could instantly see the patient's body language relax and she opened up to him about struggling with her injuries and rehabilitation. Although this had very little to directly deal with why she needed his services, the physician valued his patient enough to give her the time and space to discuss how she was feeling.

This was my first rotation and really shaped how I approach patients. During multiple rotations, I often would ask how people were doing with the COVID-19 pandemic and attempt to normalize struggling by conveying that many people are struggling during this difficult time. I have had multiple patients since then open up to me about what they are struggling with and can often deliver better care because of this. There are too many times in medicine that we cannot actually fix what ails our patients. However, we can often give them our time and always show kindness. Humanizing someone in dehumanizing times is the most important part of being a physician.

Anonymous 4

During my internal medicine rotation, we had a patient who was recently diagnosed with end-stage heart failure. Most of their last several months were spent in and out of hospitals, and the patient was struggling to perform many activities of daily living. Despite several weeks of medical management, nothing seemed to improve the patient's condition enough to allow for discharge home, and unfortunately, they did not qualify for a heart transplant. Although the patient understood the severity of their condition, they grew more and more frustrated at the fact that we would not discharge them home, and they also did not want to begin palliative measures.

It was not until we had a long discussion about the patient's goals that we were finally able to develop a plan to safely discharge the patient to palliative care. What was most important to the patient was spending time with family, and during the COVID-19 pandemic, no visitors were permitted in the hospital. Upon questioning the patient about their initial hesitation to begin palliative measures, they expressed worry that palliative care was simply comfort care during passing. We were able to counsel the patient that palliative care was in place to help them achieve their goals, such as seeing family, while still providing the maximum medical treatment to reduce their discomfort and lengthen the remainder of their life.

I am a little disappointed that I didn't try and have this conversation with the patient sooner. Even though I have been told throughout my medical education to establish a goal-directed partnership with patients, when it came to treating a patient in real practice, my excitement to be a part of the care team caused me to overlook this critical conversation. As I move forward, I hope to have these conversations regularly with patients. Starting conversations by focusing on non-negotiable items is a great way to begin understanding what motivates a patient, and I hope it will help me focus my care in a way that empowers them to achieve their goals and live a fulfilling remainder of their lives.

Anonymous 5

On my IM rotation, I was assigned a patient admitted for osteomyelitis, and as a medical student, one of my jobs was to call and update my patient's family every afternoon. For this patient, communication with his wife, Jo, was especially important because he had aphasia from a prior stroke. The first few days I called her, she was upset she wasn't allowed to visit because of COVID and did not like our treatment plans. She would scream at me, hang up on me, and question our decision making. She called every department in the hospital multiple times per day, and she was quickly labeled a difficult family member. Admittedly, I too, was frustrated with her after that first week, and I dreaded those phone calls. That weekend, I reflected on the situation, and I realized that her concerns truly were valid. She has been the primary caretaker for her husband since his stroke fifteen years ago. She knows how he communicates and knows when he is in pain. And now due to COVID, her husband is left ill with caregivers that just met him days ago, and her only communication with him and his physicians is through me each afternoon. I spent more time each day learning their story, listening to her concerns, and setting up a time each day for her and her husband to facetime. I built a relationship with Jo over the next week, and I advocated for them. As medical students, we have limitations when it comes to making treatment plans or putting in orders. But on that rotation, I became a better future physician. My relationship with that patient and Jo reminded me that while at first that phone call every afternoon seemed like a task assigned to me, to Jo it was the only thing connecting her to the updates on the most important person in her life. Now even during the hectic times, I stop and remember Jo and how her story taught me how important it is to step back each day and remember the humanism perspective of medicine.

Anonymous 6

It was 2:13am on the OB floor. A sudden ring of the intern's phone signaled an emergency. "We need to go, now," she said. We ran. We arrived in OB triage to find a woman screaming in agony. "The baby's coming!" she persisted. Without warning, she lowered her blood-soaked pants. The head of the infant was already out. In one movement, the intern threw herself to the floor, catching the falling baby. Lacking the medical knowledge to be much help, I started rubbing the patient's back to comfort her. After what seemed like hours, the peds team arrived and attempted to revive the baby. Intubate. CPR. No pulse. More CPR. After 45 minutes, the baby was pronounced. The nurses asked if I wanted to hold the baby. They said it would bring closure. Reluctantly, I reached out. I sat waiting outside the mom's room, cradling him in my arms. My attending whispered, "Holly, it's OK to be human." I lost it. The intern said the mom was ready. I attempted to compose myself, but she stopped me, "She wants to know you care." I went in and gently laid the baby on his mom's chest. We sat and cried together. I let her know that I saw her — that someone was there to share in her sadness and grief and shock. This experience taught me that underneath our white coats, we are humans first. It is such a privilege to share in the most vulnerable of moments with each other. I hope to always remember that each interaction with a patient has immense weight that has the potential to be remembered forever. I aspire to see patients as they truly are, and not just as a diagnosis.

Anonymous 7

On my pediatrics rotation, I remember an infant alone in a hospital room with a team of nurses, doctors, and specialists attempting to learn the cause of his jaundice. He was Black, and nobody on the team except for me shared that in common with him. The lack of etiology for his jaundice after multiple tests led some to suspect abuse, with his mother having missed an appointment after the baby's birth. In circumstances like these when a Black patient is accused or blamed in some way for their or their family's health, a certain solitude overtakes anyone sharing this common thread. In this case, our collective Blackness brought a wave of isolation over the mother, the baby, and me, each of us separate but strangely connected in this sense of unfortunate understanding. I wanted so dearly to encourage and believe and care for the new family, as I'd been treated this way. I knew what it's like to be misunderstood or accused much earlier in the differential diagnosis than our racial counterparts, even while it's described as protocol. And eventually, when I finally did meet the mother after her legal attempts to see her baby again, I tried to convince her to stay to both fight and receive assistance from the hospital that kept her child from her. The contradiction was too much to bear for me, as a 3rd party in this proceeding. But I remember my conversations with her, knowing my pain was nothing in comparison to her own, and how her eyes betrayed her discretion. When the team would speak with her, her gaze projected fury and deep sadness, as well as timid compliance. When we were alone, the sadness overtook us both, but her joy shone through as she was finally able to hold her baby again. Her son was eventually diagnosed with cystic fibrosis, which would ensure a close connection with the hospital system for the rest of his life. But I knew a certain trust had been broken, a guard newly constructed. In meeting this family and witnessing what happened to them, I reconfirmed that medicine and its claim to value humanism still only embraces an incomplete version of it. And unfortunately, some of the change needed can only be brought about by those who experience those insidious waves of isolation that crash down onto us. I wonder sometimes if one needs to experience the waves to be able to see and reach that unfortunate understanding or to even be willing to help still the waters.

Anonymous 8

The first time I met DS, he graciously allowed me to observe his physical therapy session. As he rolled his wheelchair through the winding halls of the hospital to the therapy gym, he was accompanied by his father, who offered repeatedly to push the chair so his son could preserve his strength. DS declined his father's offers; he was determined to make it on his own. When we arrived, he worked to gain skills most will never have to consider. He practiced transferring from wheelchair to bed. He learned to balance his front wheels off the ground to safely navigate over curbs. Afterwards, he rolled himself back to his room with sweat glistening on his forehead and determination engraved in his demeanor. He was exhausted, but he refused to be defeated.

DS is about the same age as me. We were both raised on the outskirts of the same city, and we both spent most of our youth playing sports. Weeks prior to meeting each other, he suffered a gunshot wound that severed his spinal cord. He was instantaneously and permanently robbed of his ability to use his legs. Meanwhile, I was rotating through my clerkships, fretting about exams from the comfort and safety of my home.

The tortuous path of medical education is riddled with obstacles complicating the altruistic mission that compels many to pursue this incredible vocation. Exams, evaluations, and research certainly provide opportunities for self-growth, but they also have a tendency to become the end rather than the means if we are not careful. The juxtaposition of this patient's tragedy next to my own academic preoccupations served as a powerful reminder of the true purpose of medical education. We are not here to build impressive resumes; we are here to acquire the knowledge to help other human beings. The grit exemplified by DS in the therapy gym will replay in my mind for years to come. Our patients are exerting incredible effort to overcome illness and personal tragedy, and we must work diligently to gain the skills necessary to assist by whatever means possible.