Reflections:

Learning Together, Working Together

Indiana University School of Medicine
2010-2011

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Cover Art:
Bridge
Joani Rothenberg

This picture is of a mural that features a bridge — a powerful metaphor for life's spiritual and physical journeys. It traveres a landscape of colorful and diverse "experience" elements.

It hangs in the lobby of the Western Galilee Hospital which provides care for a diverse population of Arabs, Jews, Druze and Christian patients. The mural was painted in a public space which allowed people to see themselves as partners in the process of its creation.

Note from the Editorial Board
2010-2011

The *Reflections* series began in 2004 through a partnership between the Indiana University School of Medicine Relationship Centered Care Initiative (RCCI) and the Dean's Office for Medical Education and Curricular Affairs (MECA). Each year the publication is given to faculty and students as a gift from the rising second-year Indiana University School of Medicine (IUSM) students.

It is our hope that *Reflections* will provide its readers with the opportunity to witness and understand each other's experiences, to improve our capacity for empathy and professionalism, and to foster dialogue about the quality of health care and of the relationships formed through it.

Reflections: Learning Together, Working Together contains a collection of narratives, photographs, and other creative pieces by students, residents, faculty, alumni, and staff of the Indiana University Schools of Dentistry, Nursing, Social Work, and Medicine, as well as other community health care professionals. Their works convey what it means for members of the health care community to develop through experiences—from 1934 to 2010—and through relationships with one another.

Some works, noted as excerpts, were more extensively edited for length. The full-length versions may be found online at http://meca.iusm.iu.edu.

Other works are anonymous submissions from then-third-year IUSM students who recorded "Professional Narratives" during their Internal Medicine Clerkship — reflections on interactions between health care professionals, patients, and patients' families which impacted the students.

Our thanks to all those who have shared their talents and experiences in this publication; may it provide inspiration to those who read it.

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Foreword: Together

A celebrated historian, a man who had won many awards for his writing, was invited to give an address at a great American university. In conjunction with his visit, the university's former president, a highly distinguished scholar and leader in his own right, invited him to lunch. As the two were dining, the former president asked the historian whether he had majored in history in college.

"No," the historian replied, "I was an English major. In fact, I did not take a single history course until my very last semester."

"That must have been quite a course," the former president replied.

The historian paused, looking off into the distance, "Actually, I do not remember much about it. I cannot even tell you the name of the instructor. He was not a faculty member, but a graduate student."

"So the course didn't make much of an impression on you?" prompted the former president.

"Actually, I was very inspired by something the instructor said on the first day of class," the historian replied. "He told us, 'We are going to be studying many different historical ages, events, and personages. As we do so, never forget that we are not just talking about names in books. We are talking about real, flesh-and-blood human beings, people as real as you and I.'"

The historian again looked away. "That really impressed me. I have never forgotten it. In everything I have written, I have always tried to capture the sense that we are dealing with real people who got up every morning and laid their heads down every night. They were human beings just like us, who bore children, buried their parents, and who were in turn buried by their children. They gazed up at the very same sun, moon, and starry night sky that shine now above us."

"That's a beautiful story," the former president replied, "to which I would add one coda. The graduate student who taught that course?"

"Yes?" said the historian.

"You're looking at him."

Henry Adams, one of the great American intellectual historians, once wrote about teaching: "A teacher affects eternity; no one can tell where his influence stops."

Every educator was once a learner, and every learner becomes an educator. Whether we hold a faculty position or not, to practice medicine is to be a teacher. For one thing, the title by which our patients know us, *doctor*, comes from a Latin root that means "teacher." Moreover, every interaction with a patient or fellow health professional is an opportunity to teach. We teach not only formally, with syllabi and curricula; but also informally, through the questions we ask and the examples we set.

Everyone knows that we learners model ourselves, unconsciously as well as consciously, after our teachers. We remember what we are assigned to study; we mimic the styles and phrasings of those who taught us; and when faced with difficult situations, we ask ourselves how our most esteemed teachers would respond.

Yet we sometimes forget the profound impact of learners on educators. There is a story about the behaviorist psychologist B. F. Skinner, whose students at Harvard decided to test out the theory of behaviorism on their instructor. During lecture, every time Skinner leaned to his right, the students would feign boredom, looking out the window or putting their heads on their desks. Every time Skinner leaned to his left, the students would show great interest, hanging on his every word. By the midpoint of the lecture, so the story goes, Skinner was leaning so far to his left that he fell from the podium.

Do students care about what instructors have to teach and how they teach it? Do they have learning objectives beyond the material that is going to be included on the next test? Do they realize that excellence in medicine has more to do with attitude, style, and philosophy than with facts and rules? Do they see that it is less about downloading, storing, and retrieving information than about imbibing and embodying character?

Do the members of the faculty come prepared to convey genuine curiosity, commitment, and excitement about their approach to health and disease? Do the members of the student body come prepared not only to memorize but to be challenged and inspired? What if faculty members never really invest themselves in the teaching, instead just reading their notes? What if students never really show up at all?

Education is like a dance, and it takes two to tango. Just because certain curricular material was presented in class does not mean that a faculty member truly fulfilled an educational mission.

The mere fact that seats were warmed does not prove that anyone really glimpsed what is most worth learning.

Great education is like great jazz. To respond creatively in the moment requires attentiveness, playfulness, and generosity. Like great medicine, it cannot be preprogrammed. There is no checklist or set of algorithms or heuristics. Thank God it is not that easy! If it were, there would be no illumination and no joy in it.

Instead, there is only the promise. If we pour ourselves heart and soul into it, whether on the dance floor or the keyboard, at the bedside or in the classroom, we may catch a glimpse of it. We are talking about something more than well-formulated learning objectives, sound pedagogical techniques, and high scores on high-stakes exams. We are talking about genius, something worth recalling and celebrating for a lifetime, perhaps longer. We are talking about a spark that we carry inside and, when conditions are favorable, summon forth to light anew, like the passing of a torch.

The teacher? The student? The student? The teacher? You're looking at him. Who can say where such influence starts or stops?

Richard Gunderman, MD, PhD
Assistant Professor of Radiology; Director of Pediatric Radiology;
Vice-Chairman of Radiology, Riley Hospital for Children

Learning Together, Working Together With Our Patients

"It is a mystery why physicians selectively remember such encounters…. But remember they do, and such memories enrich one's lifelong learning and practice of medicine and one's views of the broader human condition. Such encounters where the raw core beliefs and emotions of the patient, family, nurse, and physician are shared intimately are a rare privilege of being a doctor and health professional."

Stephen J. Jay, MD
Professor of Medicine & Public Health
Past Founding Chair
Department of Public Health
Indiana University School of Medicine

Meeting My Donor's Family: Excerpts

Introduction

The gift of one's own body for medical education transcends all other gifts. The donor becomes the "first patient" and the "real teacher," educating future doctors and affecting hundreds of thousands whose lives will be positively affected by all who are taught and treated by these doctors. This impact is staggering and is more than any of us can accomplish in a lifetime of service. These donors share with us the commitment to lives of service (even after death)—helping to improve the quality of human life and lessen human pain and suffering.

The cadaver donor program in anatomical education at IUSM - Northwest has many unique aspects. Critically and arguably the most important is that students know the real names of their donors in addition to the usual information received. Students write letters to the donors' families, often beginning a series of correspondence where they learn more about those who gave the ultimate gift of self to help others. Learning about the donor's life, as well as communicating with the family, intensifies the meaning of working with a "first patient." This introduces the realities of life and death that the student will face in the medical profession. This helps teach things we professionals can't teach them—things that transcend academics in "the making of the physician."

Five medical students opted to complete additional research on their donor, Dorothy, or Dot. For the students, meeting Dot's family provided a unique opportunity for reflection early in their careers. These essays provide a unique insight into the early development of the student-doctor through the cadaver experience.

Ernest F. Talarico, Jr., PhD
Assistant Director of Medical Education,
Assistant Professor of Anatomy & Cell Biology
Indiana University School of Medicine - Northwest

Dorothy's husband showed us a stunning picture of her younger self looking into the distance and another one of her smiling from a year ago. She had left behind 11 children and a loving husband. Seeing what Dorothy looked like when she was young and old and hearing a few points about her life put a story behind her. It put life in the muscles and bone. And now every time I go in the laboratory, I know that I won't just see the anatomical features, but I will visualize her younger self looking in the distance. I will see that smiling older woman.

Her donation and contribution to medicine allows my life as a doctor to begin. And with my beginning, I can help others start and prolong theirs. So to Dorothy, thank you for putting your trust into my hands so I can learn and be the best doctor I can be. You give more than just being a "study aid"; you teach us to look past the diseases and abnormalities and to understand that there is something more to learn...a life. Finally, to Dorothy's family, thank you for sharing a part of Dorothy's life, and consequently your life, with me.

Jennifer Behzadi
Student, Class of 2013
Indiana University School of Medicine

I think that meeting Mr. R. allowed us, as students, to understand an extremely important aspect of medicine—compassion. While I was in a state of extreme happiness after having just recently completed my undergraduate education and had now begun taking the first steps along my journey of medical education, Mr. R. had just recently lost the love of his life and the woman to whom he had been married for sixty-four years. We were at complete opposite ends of the emotional spectrum, but somehow we seemed to understand each other. The presence of a mutual respect for our emotional differences was almost tangible. Even though none of us had experienced what Mr. R. was feeling, we did our best to empathize, and it was clear that he was doing the same. That is compassion.

Lucas Buchler
Student, Class of 2013
Indiana University School of Medicine

What do you say, as a student, to the family whose wife and mother you are dissecting? A surgeon can cut, slice, remove, reorganize, rebuild, and perform any number of activities that very few human beings are allowed to do; and in the end the patient and family can usually leave the hospital in better condition than they entered. We are privileged to be able to examine, manipulate, cut, learn, and perform with much less precision than the skilled surgeon; but in the end it is without the relief to the patient and family that a successful procedure brings. No matter how successful we are as students; no matter our diligence, our care, our utmost respect for her decision and gift; our first patient will not be benefited by our work. She will not walk out with her family when the day is finished.

Mr. R. asked us, "Why do you want to go into medicine?" He asked us individually and listened intently to our answers. It seemed like he and his son wanted to know who we were and why we were here if we were going to be spending time with Dorothy.

Michael Burk
Student, Class of 2013
Indiana University School of Medicine

In truth, it is very difficult to meet the family of someone who has chosen to become your first patient, not because we don't appreciate their gift, but because there is no hiding the fact that we are dissecting their loved one with very inept hands. To my surprise, however, I found that the feelings of unease and almost embarrassment began to subside as I learned about my donor. I learned that rather than staying "objective" by maintaining my distance, I was able to take on the greater meaning and find interest in my patient by learning who she was emotionally and spiritually, rather than just physically.

I still find myself learning about what is the "right" thing to talk about with Dorothy's husband and family. When you are at work as a physician, all of your talk to family centers on how you are helping their loved one. Here, in this role reversal, they want to know how their loved one is helping you. I think the simplest explanation to that inquiry is that they are helping not only us, but every patient we will ever see. As students we make mistakes, and Dorothy is the one that forgives us our errors. She harbors no enmity for our missteps, no anger for our naiveté. In the simplest

way, she is encouraging us as students to explore and learn so that we might help others. I think that her husband would be happy to know that, even after her death, she lives on in all of our future patients.

I find myself trying to thank her in the only way I know how: by treating her with respect, avoiding any unnecessary roughness, keeping her in the best condition possible, and showing her husband the incredible gift she has given us.

Lyndsay Langbehn
Student, Class of 2013
Indiana University School of Medicine

Paul is also currently involved in research on Dorothy.

While I could pore over anatomy books for several hours every day, I did not appreciate the intricacies of the human body until we began to learn from Billy. This physical learning in and of itself was both enlightening and fascinating, but it paled in comparison to meeting his family. Billy spent his life working for a pharmaceutical company and was the beloved grandfather of a wonderful and loving family. Now, he would give the final chapter of his life to my learning and understanding of the human body. Thank you, Billy, for your generous gift and for letting your family provide me a new appreciation for both the honor and responsibility of being a doctor.

Paul Connors
Student, Class of 2013
Indiana University School of Medicine

Hoping and Learning Together: A Journey with Cancer

Staff nurse Meridith (left) lives with cancer while caring for children like Darcey (right) at Riley Children's Hospital Cancer Center. The young cancer patients have helped Meridith learn how to live and work while fighting cancer. Meridith says Darcey's resilience has taught her that life goes on even when you are sick.

The staff in the Hematology/Oncology Clinic and Riley Children's Hospital Cancer Center applaud Meridith's approach and dedication to her profession while living with cancer.

M. Elaine Southwood, RN, MSN, CPNP
Riley Hospital for Children

Help Along the Way

When I went to college, I was grateful to my parents and all the support and encouragement they gave me growing up. Entering medical school, I appreciated my mentors and friends who helped me break out of my shell and find my way. Starting my third year of medical school, I felt obliged to my professors and peers who helped me navigate through thousands of pages of material and endless hours of lecture in those first two years.

Working on the wards for a year now, I am deeply indebted to my patients. I have forgotten quite a few of those details which seemed so important at the time, but I realize that I have learned far more important lessons and have retained vital concepts because of them. Although my patients are often the ones who say "thank you" to me because I have taken a minute to answer their question, I am grateful for all the stories, hardships, and joys they have allowed me to be a part of because this is what has truly molded me into the physician that I will be.

Stephanie Nothelle
Student, Class of 2011
Indiana University School of Medicine

"Art Lesson" and "Martha's Cane" are reflections written by students from the IUSM - Lafayette campus. For their Introduction to Clinical Medicine course at Lafayette, students are paired with "neighbors" in the community whom they visit regularly during the first semester of their first year; they often continue to call on their "neighbors" throughout their two years there.

Art Lesson

The retired accountant-artist took me on a tour of his home that also serves as an art gallery. Slowly he slid to the edge of the couch, rooted his feet, stood up with his cane. After a moment he began to walk, shuffling first to the fireplace. He worked mostly with pastels. He stopped teaching painting courses only recently and only because the Parkinsonian tremor made it impossible to paint the way he did before.

I praised the painter for his beautiful work. "Where's the scene in this painting?"

"Michigan."

"I love the colors--the lavenders, the sky blues…."

"You know what makes them stand out, right?"

"What's that?"

"The darks."

All art lessons are life lessons.

During the semester I spent with Bob, he advised me on how to finish a painting I had started in a summer course; again he emphasized the importance of contrast. When I finish the Venetian scene, I will not be afraid to paint the buildings, dock, boats, and hooded figure darker than I had planned so that the light, bright beauty of the sunset and water glows. Bob was happy and comfortable back in his role of art teacher as well as in the other role he played for his previous students: a teacher of life lessons, or more simply, of hope and perseverance. They called his course "Mondays with Bob," a spin-off of Mitch Albom's book title *Tuesdays with Morrie*.

Perhaps his comment about the darks highlighting the lights was purely technical advice, but to me it meant more. His struggles with his health, I think, highlighted for him his years of good health, his wife's dedication, his appreciation of the ability to paint. He had not even discovered painting until after retiring

from life as an accountant (but, thankfully, years before he was diagnosed). This reminded me that while storms may come, there also may be meaningful and wonderful chapters of our lives which have not yet begun.

After the tour and more conversation, his wife, who had been mostly quiet on this first visit, sighed in the still living room. "I'm sorry we're so boring," she laughed.

I cannot wait to unearth my oils, brushes, and canvas—yet unfinished but now full of memories of my Sundays with Bob.

Carrie Rupprecht
Student, Class of 2013
Indiana University School of Medicine

The unfinished painting; photograph taken by my sister, Julie Rupprecht

Martha's Cane

Martha and I [her cane] have been together for a very long time now, and over these many years I've felt a gradual dependency. I enjoy Martha's company, but sometimes she'll forget where she left me. She swears at me too. She's always grabbing me up and saying how she leaves "this damn thing " everywhere. After she lost her sight, things got even worse. I can be sitting right next to her on the arm of the chair, and she'll start fumbling about for me. I've tried calling to her before, but I've given up on that as she doesn't speak "cane" very well. The loss of her vision as well as her ever present dementia has put a rift in our relationship, but I'll never leave her side.

I'm a part of her daily routine, and I even get to sleep by her bed much like a faithful pet would. Each day I witness her interactions with the world. The morning prep is always interesting. My former friend, the mirror, just sits there mocking her clouded vision. She gets her hair done every Thursday, and you'd think that by the following Wednesday it would need done again. However, each day she painstakingly finds each of those stray hairs and puts them exactly in place.

…Tying shoes, putting on a shirt, jewelry; these tasks are second nature, and she does them as if she could see. I always let out a little chuckle when she reaches for my other friend, her glasses. They don't do her one bit of good, and I think she wears them simply out of habit. I'm afraid her glasses would be hurt if I told them they are no use to her. You see, I think I'm more useful than her glasses. Sometimes she bumps me into things to see what's in front of her, but I don't mind.

We don't go out much. Martha likes a routine. She has a few visitors that come by on occasion to help her with her errands. I can sense Martha's hesitation regarding these visits. This new guy, a medical student I think is what he called himself, started coming around and takes her to the post office to collect her mail then to McDonald's for a black, senior coffee. When he first started coming, she had to write his name down a bunch of times on the notepad in the kitchen. I still can't remember his name, and asking Martha would be useless. However, they seem to have a lot in common. For instance, both of them have a great interest in flying. She's beginning to trust this guy. It comforts her when he calls her name as soon as he pulls in the drive so she knows who is there.

Although I'm there to protect her, she is always in tune to who is around her. Martha likes what she knows and she knows her house, McDonald's, and the post office. She's pretty independent and relies on others only when it is absolutely necessary.

When Martha walks into the post office, she'll often give me a brief break. I get to hang on her arm while she counts the rows of boxes: 1, 2, 3 until she reaches hers. My other friend the key sometimes plays tricks on her and will orient herself spikes down. It doesn't take Martha long to quell my friend's mischievousness. Martha trusts the people at McDonald's to give her the correct change. She even has a method for storing her money in her purse. I think she enjoys talking to this new friend of hers, but I was still skeptical until he helped fix my best friend, the organ.

My friend, the organ—Hammond's his name—hadn't been doing too well lately. I'm sure it was the organ flu, but I couldn't convince anyone of it. It took some time to get it up and running again; and when Martha sat down to play, it was as if she regained her sight. At that moment, all of my friends, the chair, the couch, the lamp, the painting, the cabinet, and the bookcase all tuned their ears. At least it was better than that kid who was playing previously. Those arthritic fingers that give Martha so much trouble fixing her hair and writing were suddenly flowing gracefully across the keyboard. She made a funny comment to the young gentlemen with her. She told him he didn't need music because it should all be in his head. This coming from the one with dementia. I rolled off the piano bench laughing and, for doing so, got cussed at again.

Martha and I get along alright, but lately she is worrisome and lonely. Being blind leaves you plenty of time to stare into the darkness and think with little distraction. She's not as independent as she used to be, and she frets about the reality of being 94 years old. She sees it in the life of her friends.

The other night, Martha couldn't sleep. She got up out of bed and, taking me with her, we went to the living room. Martha's strife was carried away in the soft vibrato of "The Old Rugged Cross," her favorite hymn.

Benjamin Randel
Student, Class of 2013
Indiana University School of Medicine

Teaching Hospital

Lying on crisp, pressed sheets, he smiles a knowing smile
As I palpate and auscultate his frail body to no avail.
He tells his story for the tenth time this week.
"You should listen to this," he enthusiastically prompts me,
And directs me to his symptomatic chest.
Lists of signs, medications, and a family history scrawled on my form
Will yield no meaningful information to save him now.
His weak hand grasps mine as we part;
He says I'll make a fine doctor one day.

The words of encouragement from this dying man
Bring tears to my eyes as I walk home in the dark.
A desire to earn what has already been given overwhelms me.
A deeper understanding of my responsibility and privilege helps me
Persevere along my path.
While it often seems dark and fraught with doubt and difficulty,
The way is lit up by those I am privileged to care for.

Now, passing by his empty room,
I remember the words of my teacher
Who in his final moments
Gave me the greatest lesson in medicine.

Shafer Kurshuk
Student, Class of 2011
Indiana University School of Medicine

"Eula" was drawn from my experience as a resident in medicine. "Eula," with severe chronic obstructive lung disease, trained hundreds of students, interns, residents, staff and faculty, as she had numerous hospital admissions each year for respiratory failure over the last 10 years of her life.

Eula

Morpheth, starched and capped, said
Eula was back and wanted to see her new Intern—
Whose nervous steps echoed on ceramic trillium-tile and tread,
By Walnut-framed doors
Under the vaulted corridor past window urns
Then two-at-a-time up sand-worn steps to the quiet floor.

She sat straight-backed against starched white pillows;
Spread across her lap a nascent lavender snow-shawl
Accreted form and life from hooks of apple wood willows,
As her knotted fingers traced illusory pirouettes,
And her eyes, blue and wan recalled
A thin expectant smile for Intern met.

The translucent mooring-cannula angled from Eula's face—
A half-moon-arc to the green cylinder-head
That cast its sun shadow across the bed in waning grace,
From sun streaming through the open window of these worlds—
Through Live Oak leaves and dust motes—ancestral warmth shed
In joy etched in the memory of a young girl.

Through August languor broke the hiss—
And provoked memories—from the stainless valve at cylinder's top—
Its red ball dancing two liters per minute with oxygen air mix—
She was seven with fear—Father's bee hives moaned in his last summer;
The Intern lecture in July: should he consider other flows—or not?
Both met after interlude with reassuring nods and murmurs.

He asked to examine and sat beside her to explain—
Another young doctor to probe, adjust, encourage, and listen.
Her hand was cool, clubbed and tar-stained—

As they embraced an embarrassed glance
And his stethoscope bridge flesh between ribs chastened—
Faint sounds of air eddies wafted across lung caverns by chance.

His finger plectrum struck hollow chest tone of ancient style;
She tugged breath in, then urged it out past sweat beads on pursed lips—
Five, seven, ten seconds—another tug, as his eyes darted from dial
To a stoic face edged with fear and ache
She recalled red balloons and ebullient childhood bliss
To blow and blow…candles of her third birthday cake.

Eula asked he stay
And returned to the hooks and pulling bright yarn—
He sat close—medicine and succor at bay,
The rhythmic clicks of wood on wood—pattern choices,
Rustling free air from the window, nearby oaks and distant farms,
The faint hiss—misting Eula's quiet voice—

"I'm alone—family has gone ahead"—
"Guess I'm corralled now"—
Her words stark and bare—cogwheel dyspneic shreds—
"We could ride—granddad and I—through sunset's burl"—
"But always felt sad in [a] way—when we penned—the cows
At the ranch—in West Texas—when I was a girl."

"When did it begin?" He asked;
"The '50s—you think—you see it—in the corner of your eye"—
"But pass it—and deny it would last"—
"Then the stairs to my 3rd floor"—
"The block walk—yard around—the oxygen—tie"—
"Tethered—like the Pintos we reined—at dusk's hour."

Eula smoothed the shawl as artists must,
And with the apple wood hook brushes
Painted what dyspneic words failed to trust—
Her sticks raced for this 35th shawl—for his Tess—
One every five days—for her new family trusts
And her purpose no less.

Her smile thanked his patients for her story's bother,
He rose to duties called; she drew his gaze to the pine bed-stand—
A faded image of a happy girl in chaps and mother.
"I'll stop by later"—and he held the door agape
As the maid, bent and gray, greeted Eula with ritual and
Private prayers for her and previous tenants of 408.

The Intern stopped hesitantly onto the sea of trillium,
Past flowered urns' afternoon shadows cast,
Walnut cathedral arches and murmurs of requiem
Down the sand-worn stairs as he sought meaning
Of an indomitable spirit, science, and technologies' grasp—
And ancient mysteries of doctoring.

Stephen J. Jay, MD
Professor of Medicine & Public Health
Past Founding Chair
Department of Public Health
Indiana University School of Medicine

A Reflection on Two Letters

Graduating from medical school should be a happy occasion. It was, for the most part, while I thought about the things I had learned from the wonderful people at the Indiana University School of Medicine. But I thought about other things, too, like the two lung cancer patients I cared for in March.

One of them passed away while I was in her room. She was a kind woman who kept worrying about her children and whether or not her home was staying clean. I am lucky because I had an opportunity to sit down and talk with her when I was on call one night. That's the beauty of being a student. The second patient passed away five days after I left service. He was a grumpy alcoholic who came into the hospital only after his chest pain stranded him in a chair. He asked me about going back to work when he got out of the hospital. Nobody wanted to tell him he wasn't going home. Then I thought about the man who lived on the ward for over a month, mainly due to his lack of insurance. He and I became good friends. I thought about these people who had taught me more than a text book ever could, and tears welled up in my eyes.

I was probably the only person sitting in the graduation lineup trying not to cry, but I think that these patients and others like them are the ones who taught me the most about what the title of "MD" stands for. It seems like a very small title next to the person diagnosed with "chronic inflammatory demyelinating polyradiculoneuropathy." But I am proud to have received it at IU.

Lena Franklin, MD
Indiana University School of Medicine Class of 2010
IU/Methodist Family Medicine Resident

Learning Together, Working Together With Our Families

"I can't think of anything to write about except families. They are a metaphor for every other part of society."

Anna Quindlen

When a Twin Dies

I became pregnant for the first time in 2002. Immediately, I made an appointment with my obstetrician/ gynecologist and read everything that I could get my hands on about being pregnant. Upon learning that I was expecting identical twin girls, visions of pigtailed twins danced in my head. Unfortunately, I suffered several life-threatening complications and the twins, Josephine (Josie) and Abigail (Abbie), were delivered eight weeks early. My tiny, premature daughters suffered from undiagnosed twin-to-twin transfer syndrome and were admitted to the NICU at Riley Hospital for Children.

When my twins were 28 days old, Abbie developed necrotizing endocolitis (NEC) and underwent surgery to try and save her life. Thirty minutes after the surgery to remove the dead bowel, Abbie's neonatologist took us into a small room. Despite the best efforts of the team, Abbie could not be stabilized and was dying. To their credit, Abbie's neonatologist and nurse prepared us for the situation. I can vividly remember her neonatologist telling us gently but firmly, "Abbie is going to die. We cannot stabilize her. We have tried everything to save her. I will not keep putting her through the stress. You need to go in there and hold her because she deserves to be held. You need to go in there and give her the love that she deserves. Take your time. We will do what we can to support you. When you are ready to take the vent off, you can let us know."

Walking into the module and seeing Abbie lying in her warming bed was frightening and completely beyond my comprehension at the time. I simply could not process what was happening to my daughter and to our family. Almost eight years later, I am still at a loss to describe what I saw that day.

Abbie's nurse could see that I needed help figuring out what to do to make the most of the precious time that I had left with my baby. She offered suggestions of things to do, such as giving Abbie a bath and videotaping the bath. These things may seem trivial, but I am so grateful to Abbie's nurse for suggesting them because I will always have these memories of lovingly caring for my baby. Her nurse also cut some locks of Abbie's hair and made hand and foot molds for us.

About three hours after the surgery, my husband signed the papers to remove life support. Surrounded by her Pastor

and extended family, Abigail Loraine Stratton quietly died in our arms.

Josie remained in the NICU for a few more weeks after Abbie died. I will never be able to fully explain how hard it was to walk back into the NICU and see the same doctors and nurses again. At times the grieving process was complicated because of the fact that my twins were identical. Josie is in no way a substitute or consolation for losing Abbie. I was given two daughters. I love Josie for the Colts-loving, über-pink girly-girl that she has become. I loved Abbie for who she was ,and now I cherish her memory and the time we had together as a family.

I chose to see our story as an example of the wonderful things that can come out of sorrowful tragedy. Although we never stayed at]the Ronald McDonald House, we collect and donate pop tabs ("Abbie Tabbies") to our local [one] around the anniversary of Abbie's death. In the beginning, it was mainly to satisfy my need to do something—anything to remember Abigail. Years later, donating "Abbie Tabbies" has turned out to be a great vehicle for my family (which now includes Hannah and Juliana) to talk about their feelings and ask questions about Abbie. My husband and I try to make the "Abbie Tabbies" donation a positive family event. Before we donate the tabs, I sort out 2.13 pounds of tabs into a bag so the girls can feel how much Abbie weighed. We take a picture of our girls making the donation and keep the corresponding "thank you" card from the Ronald McDonald House. What started as Abbie's baby book has become a scrapbook of the volunteer work or donations that our family does in her memory. In October 2009, family and friends helped us make our biggest donation yet…11 pounds of "Abbie Tabbies"! This is really amazing when you consider that most people buy bottled soda these days.

Our story touches on many issues facing NICU families. It is my hope that our story offers medical professionals insight into some of the unique challenges facing families of twins and higher-order multiples, with special regard to the pressure of returning to the NICU after a twin or higher-order multiple dies.

Renée M. Stratton, MS, CCRP
MPH Student, Class of 2013, IU School of Medicine
Research Associate, IU School of Nursing
Secretary Officer for the Family Advisory Council; Family as Faculty,
Riley Hospital for Children

Dr. Mom

As my second year of med school came to a close, I was asked to reflect upon what people or circumstances have been most instrumental in my personal development. I immediately thought of my children and of my role as a parent. As a mother I am continually reminded of the necessity for perpetual growth in patience, wisdom, compassion, and innumerable other qualities which are invaluable in the practice of medicine. One situation that specifically demonstrates the type of growth I am speaking of involved dealing with a conflict regarding my son and the director of his school's aftercare program.

Timothy is seven years old and has Asperger's syndrome and sensory processing disorder; in spite of this, he has functioned very well in a mainstream classroom environment. However, with the advent of a new director at aftercare, he ran into some problems after school. I came to pick him up one day and found him sobbing in a corner. The director quickly approached me and explained that he had been inconsolable and very disrespectful. He had had a disproportionate response to being shoved by an older boy during a game, and when she had tried to reason with him, he would only cover his ears and tell her to stop talking; he'd been crying for almost an hour. She was visibly upset. I assured her that we do not want our son to be disrespectful and that I was sorry his emotions had gotten so out of hand. I told her we would talk to him at home, and then I brought up the fact that sometimes it is possible to gauge when Timothy is getting overwhelmed and how it is often easier to pull him out of an escalating situation then it is to calm him down after he's "melted down."

She knew he was on the autistic spectrum but did not want to hear excuses because his behavior was disrupting the environment and it was unacceptable. I quickly realized that it would not be possible to help her better understand his sensitivities and that she just needed to vent about her frustration. After listening for a bit longer and reassuring her that I would talk to him, I brought my crying son home with me. The next day, he was in tears again. Overreacting and inconsolable, she could not handle him like this I was told.

I was at a loss, but after some consideration, I sat down and wrote a letter to the director. I let her know how much I appreciated the safe and engaging environment that she provided

for Timothy, and again I apologized for the frustration that I knew she must be experiencing. As someone who has dealt firsthand with his emotional outbursts, I knew how exhausting they could be. I then went on to tell her about what Timothy was like before his diagnosis and speech, behavioral and occupational therapies. He didn't run, play, slide, or laugh with other children. He seldom even spoke to them. Now, though, he sought conversation and socialization. However, engaging meant opening himself up to a world of stimuli which could become overwhelming to him. Recognizing his sensitivities and when he was becoming overwhelmed made it possible to help him contribute to the community, instead of disrupt it.

I purchased some chocolate and stationery, a monogrammed bookmark, and a book about sensory processing disorder; and I brought it, along with the letter, the next time I picked Timothy up from school. I expressed my gratitude and gave her the gift.

I could not be happier with the outcome. She has become one of his biggest advocates at the school. Several times I have come to pick him up and while all the other children are on the playground with the college-aged helpers, Timothy is inside laughing over a board game with the director. She has become adept at engaging him and understanding his sensitivities in a way that enables her to provide him with a comfortable environment in which he can thrive. On his self-assessment last trimester, he put that his favorite activity in the school day was aftercare.

This story is not one of a clinician. It is the story of a mother, but I believe that in many ways parenting will play a crucial role in shaping me as a physician. Communication, problem solving, professionalism, ethical judgment, and self-awareness were all critical in coming to a successful resolution in this conflict, and these same skills will be drawn on as I practice medicine. Lifelong learning is indeed a necessity for physicians, and for moms.

Shannon F. Renfrow
Student, Class of 2012
Indiana University School of Medicine

My Definition of Success - Be a Teacher: An Excerpt

My parents set the value system which makes me what I am today. My father is a retired anesthesiologist and my mother an excellent homemaker.

For my father's "call duty" for emergency requirements, an ambulance with a driver had been assigned. Although many people told him he could use it on a regular basis, he refused to do so and told us that this was an expensive resource given by the government for their emergencies *only*. ***That was our early lesson in utilization and respect for resources.***

Every person connected to my father's workplace was treated with respect, and we were taught that they were all part of a larger family. ***Treat people at all levels of work with respect. It is more important to respect your subordinates than your superiors.***

Our morning routine started with tea and a brisk round of discussion based on the daily newspaper. After reading the newspaper aloud, we were told to fold it neatly. My father used to say, "You should leave your bed, newspaper and toilet the way you expect to find it." ***Show consideration to others and be disciplined.***

When it was mentioned that we still did not have a television set or even a house of our own, he would reply that he already had three houses—referring to us three children. ***We learnt not to measure personal success and sense of well-being through material possessions.***

I grew up wanting to be a physician, studied hard, and made it to the dental school in Calcutta, India., but I had this notion that I would be more useful as a physician rather than as a dentist. I took a trip to a dental camp in West Bengal, India. There I saw abject poverty, pain and suffering; serving those people made me realize that one does not need to start at the top, but work one's way to the top, and big things of life can be built from smaller things. From that time I began to carve my life's own journey. The USA was a dream destination. I started my work towards that goal. When I was about to begin my private practice, I was challenged and struggling with the new experience. I shared my feelings with my surgery professor, who said, ***"Son, if you are challenged and you feel frustrated that things aren't going too well, it means that you are going places."***

I practiced general dentistry including a four-year stint with

the Ministry of Health, Kingdom of Saudi Arabia. After I returned to India, I slowly realized I had to be a clinician as well as a teacher. This saying by Aristotle came to me from my father: ***"Those who educate children well are more to be honored than parents, for these gave only life, those the art of living well."***

One day I told my father that I disliked my social sciences teacher as she repeatedly asked me questions. "Son, this means she loves you the most and she wants to be a part of your success." Later I realized that this questioning and quizzing made me a better resident and pathologist. ***Success is not about the ability to create a definitive dogmatic end state; it is about the unfolding of thought processes, of dialogue and continuum.***

Life in the United States six years back when I started my residency was tough, relentless, and backbreaking. I was without my family, had moved away from comforts to a life full of struggles. I worked outside to cover expenses. The gas station and the convenience store boosted my confidence to deal with people in a new land. These places of work also became my third learning sites.

The most painful experience was to mop floors before closing time [when someone broke] a wine bottle. Watching from the corner of my eye as the last bus passed by, I knew I had a tough five-mile walk back home in the dull, drab, lonely and rainy night. The only vision I had in those moments was of a beautiful life teaching and inspiring young students to continue this journey of knowledge, not to be deterred by the little problems faced. These situations made me tougher and softer at the same time.

Textbooks can always impart knowledge if someone is literate enough. I truly believe that today I am a teacher to inspire the new student, to ignite the desire; and if I can do that, the rest will follow! And as a clinician I want to serve the community in the most fair and just manner possible.

If we can imagine a future, we can create it; if we can create that future, others will live in it. That is success.

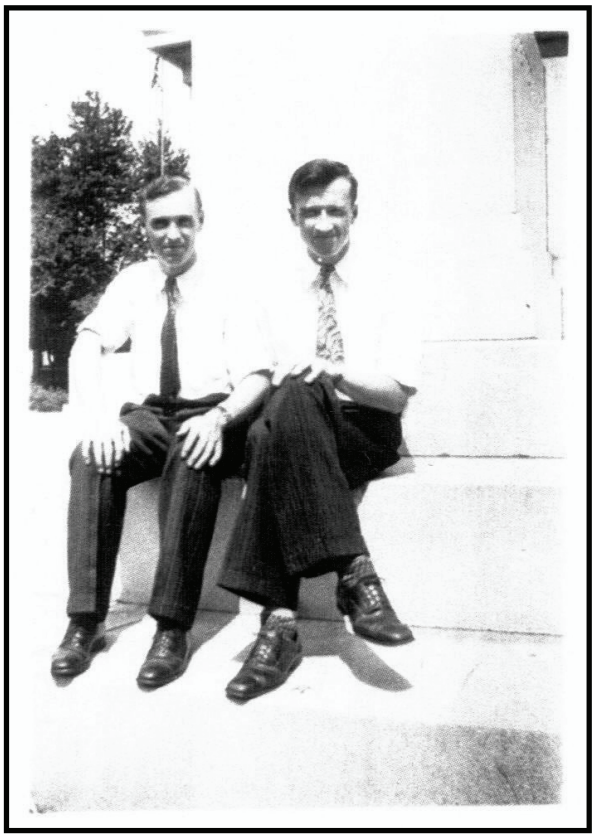
It is not about what you create for yourself; it is what you leave behind that defines success.

This nation provides us the opportunity to think, to dream, to be inclusive and to share with others your dreams.

Go, kiss the world.

Nadim M. Islam, BDS
Assistant Professor
Indiana University School of Dentistry

My father Robert Samuel McElroy, MD (1905-1994), and his younger brother, James Stewart McElroy, MD (1907-1977), were said to be the only non-twin brothers graduating from the Indiana University School of Medicine in the same year, 1934. Those were the dark days of the Depression. If memory serves there was a "soup kitchen" in the Fesler Hall basement at one time. Their sister J. helped with medical school costs by raising and selling turkeys. Dad took his internship in Lafayette primarily under the tutelage of a surgeon. Brother Jim stayed at the Medical Center taking a residency in internal medicine and subsequently a surgical residency under Dr. G. A few years ago, I came across a paper that Uncle Jim and Dr. R. published in the Annals of Internal Medicine in 1939 on hypothyroidism.



Robert S. McElroy, MD (left), and James S. McElroy, MD

My father went into practice in Princeton, IN, and Uncle Jim went to New Castle, IN. With the onset of WWII, Dad was commissioned as a captain in the US Army Medical Corps in February 1942. Dad shipped out to England in the late fall of 1943 as a surgeon with the 97th Evacuation Hospital and promoted to major. The 97th Evac landed on Utah Beach D-Day plus eleven and operated till the end of the war in Europe. During the Battle of the Bulge, the 97th Evac was "naked" with no US troops in front of it but was not taken by the Germans. Later my father was part of a medical team investigating

the Malmedy Massacre. Still later he led a medical team that was the first into Buchenwald. His sleep was plagued with nightmares for over twenty years with what he had seen and experienced in Europe.

Uncle Jim was commissioned as a major and medical officer in the Army Air Corps. He was a surgeon serving in hospitals in Libya, North Africa, and Sardinia and throughout the Italian campaign. Many bomber crews would be badly shot up from flak, complicated by hypothermia and frostbite, and require extensive surgical treatment.

The brothers met briefly in Florence, Italy, after V-E Day. They did not meet again until Thanksgiving 1945 in Scotland, IN, when I was six years old. The joy of reunion with both of these larger-than-life figures who had been away so long was an emotional landmark for our family and remains for me an indelible memory.

I graduated from Indiana University School of Medicine in 1965, followed by internal medicine residency and gastroenterology fellowship at IU Medical Center. My turn at war came in 1970-1971 with a tour in Vietnam, serving the first nine months as an internist at the 12th Evacuation Hospital in Cu Chi and the final three months at the 95th Evac in Danang.

The experiences of my father and uncle in wartime and peacetime were major factors in shaping my outlook and decision to go into medicine. They were both men of compassion, skill, excellent judgment, and honor. The mentorship that began in the family continued at IUMC with exceptional physicians.

Robert J. McElroy, MD
Indiana University School of Medicine Class of 1965
Intern, Resident & Fellow, Indiana University Medical Center, 1966-72

Observing the care of a terminally-ill patient was inspiring to me. I was able to witness cycles of improvements in the patient's health as well as declines. It was apparent that the patient's life would likely end soon. The efforts and interactions between the medical staff and family resolved their desire to see her out of the hospital for her final days. Although it was hard to hold off on providing care that is available, it required a high degree of integrity to recognize that the patient's best interest lay in her release from the hospital and allowing the patient to spend the remainder of her time with family. The continued dialogue allowed me insight into the importance of family values in the practice of health care.

Student, Indiana University School of Medicine

Some people come into our lives and quickly go.
Some people move our souls to dance.
They awaken us to understanding with the passing whisper of their wisdom.
Some people make the sky more beautiful to gaze upon.
They stay in our lives for awhile, leave footprints on our hearts.

Anonymous

Learning Together, Working Together on Our Journeys

"Telling stories can be healing. We all have within us access to a greater wisdom…. Listening to stories also can be healing. A deep trust of life often emerges when you listen to other people's stories. You realize you're not alone; you're traveling in wonderful company. Ordinary people living ordinary lives often are heroes."

Dean Ornish, MD in foreword to
Kitchen Table Wisdom:
Stories That Heal
by Rachel Remen,MD

"I Learned About Myself as a Person": An Excerpt

I was on-site at a rural HIV clinic just outside of Eldoret run by Dr. Mamlin, Field Director of the IUSM-Kenya Program, when I turned around to see a young Kenyan woman in her twenties sitting in a wheelchair outside of the door. She and her aunt and husband had driven six hours to see the infamous "Mzungu" (white) doctor who they hoped could help them. The woman in the wheelchair appeared dehydrated with cracked lips and sunken temples. Her warm-up pants and button-down shirt swallowed her emaciated body, and her small head was covered with a black sock hat. I had never seen someone so wasted and frail. Still, she was strikingly beautiful.

We wheeled her into the tiny exam room, with her aunt following shortly behind. Her husband was nowhere to be found. The Swahili translator sat down beside our patient and asked her name. Her aunt indicated that the patient's name was Ann and that Ann had difficulty hearing. Dr. Mamlin had the perfect solution. He put the earpieces of his stethoscope into Ann's ears and held the bell of the stethoscope to the translator's mouth as she was speaking. It was simple but brilliant and worked beautifully. Ann was able to tell us in a combination of Swahili and broken English that she had been diagnosed with HIV by two different physicians. She had since developed a severe peripheral neuropathy and had been unable to stand or walk for weeks. She had also been complaining of diarrhea for the past few days.

We discovered that she was being treated with a dose of Stavudine that was way too high for her body weight. Dr. Mamlin bluntly told Ann's aunt that if Ann was not admitted to the hospital immediately, she was going to die. Oddly enough, her aunt still insisted that Ann was going home. Ann's husband walked through the door, and Dr. Mamlin reiterated to him the urgency of the situation. After several minutes of emotionally-charged discussion, Dr. Mamlin finally told her family that we were taking Ann to the hospital and they were going to have to try to stop us. He then offered to pay for any portion of the hospital bill that they could not afford. That was all it took for Ann's family to concede, and they even offered to drive Ann to the hospital. We quickly vetoed their offer just in case they decided to take a detour in the direction of their home. Dr. Mamlin pulled me aside and said that

Ann was going to be admitted to our ward team. He asked me to look after her as my patient, but as importantly, he asked me to look after her like a sister.

We arrived at the emergency room and carried Ann inside. We got Ann situated and brought her some yogurt, a drinking cup, one spoon, and a plastic bowl. Each patient has to buy utensils, as they are not provided by the hospital. My colleague returned with chai and bread. We pulled her up and propped a wooden stool behind the mattress so Ann would be able to sit up. I sat down on the bed next to her, dipped the bread into the chai, and hand-fed her. She ate like she had never seen food before. I was happy to see she had an appetite.

Knowing that I would need to play an integral part both emotionally and medically if Ann was going to make it was overwhelming. I was determined that Ann would make it, and I would do everything in my power to ensure that she did. Dr. Mamlin told me to make sure I found a way to get Ann anything she wanted to eat. And so began my mission to fatten Ann up.

Sometimes I would hand-feed her; sometimes she was able to eat on her own. Throughout her meals, Ann would talk to me in broken English. We were becoming great friends. One day Ann said to me, "I want to walk. I haven't walked in so long." It was time to start physical therapy.

The next day I walked into Room 3 and there was Ann, attempting to stand with the help of the physical therapist. I quickly ran over to help out. ...After we sat her back down onto the bed, I asked her how she felt. She raised her arms over her head and flexed her muscles. "I feel strong," she said with a huge smile on her face.

The physical therapist came to work with Ann every afternoon. Unfortunately, I would not be there to see Ann walk. It was time to leave Africa.

I dragged myself into the medicine wards for the last time. I dreaded saying good-bye to Ann. I put on a smile so she wouldn't have to see me sad.

I stood there for a minute and looked at her. Her cheeks had filled out, and she looked much better compared to when she was admitted. She just had to make it out of the hospital. But what if she didn't? I couldn't seem to hold back the tears. My tears seemed to trigger hers, and we both sat and cried.

"Why are you crying?" she asked me.

"Because I don't want to say goodbye to you," I said to her. But there was a lot more I did not say. I was crying because Ann made me realize what I love about being a doctor: my relationships with patients. Like every medical student, I find the science to be fascinating; but it is my relationship with patients that drives me. There is no better feeling than investing yourself emotionally and medically in a patient so close to death and being part of a remarkable recovery. I invested in Ann, and Ann made me feel like I made a difference in her life. I received an e-mail recently from a colleague still in Kenya. Ann was discharged from the hospital several days ago and walked out of the wards on her own two feet.

My experience in Kenya has given me insight into the Kenyan culture and mind-set. Despite the lack of resources, Kenyans are proud, resilient, and appreciative of what they have. Even during my time spent in the hospital, I never once heard a patient complain of a lack or poor quality of food, a lack of resources, or even physical pain. It was a true wake-up call to realize that we, as Americans, take so much for granted and have entered the mind-set of expecting the best care and facilities. Even more amazing, we feel entitled to them. Kenyans, on the other hand, feel nothing but appreciation for what little they have. I grew to love the Kenyan people and the country of Kenya as a whole. I learned about myself as a person. I recognized the need to appreciate all that I am provided with in America, as there are people in Kenya who, in their entire lifetime, will never experience opportunities that I have experienced in my 26 years of existence.

I love Kenya. I love the warmth of the people. I love the spirit of the people. I love the landscape and the animals. I love the music. Kenya, quite simply, has etched its way into my heart. Sadly, I will not be returning to Kenya as an IU resident, but because of my love for Kenya, there is not a doubt in my mind that I will find a way to return someday.

Sonali Sakaria, MD
Indiana University School of Medicine Class of 2005

My two sons and I were visiting a Masai Village in Kenya where we met a young man named Steven, who was our guide through the village. It turned out that he and my older son Max were about the same age, and the two of them got to compare notes as teenagers and as kids from very different cultures. Steven described to Max that he was the only person in his village to complete high school and that he was becoming a leader in the community given his level of education. Max said that he had no idea at this point in his life what his life held in store for him. (He was 15 at the time.) The two boys had a wonderful conversation and had clearly engaged when I snapped this photo just as we were leaving the village For me this photo is a reminder that no matter where we come from or where we're going, there are always opportunities to form meaningful relationships.

Richard Frankel, PhD
Professor of Medicine & Geriatrics;
Senior Research Scientist, Regenstrief Institute,
Indiana University School of Medicine

An International Social Work Experience

When I entered the Master of Social Work program, I was not sure which concentration I wanted to focus on. It did not take long for me to realize my passion for the medical field.

For my final practicum, I worked at Groote Schuur Hospital (GSH) in Observatory, Cape Town, South Africa. There are about 20 social workers at GSH. It is a government teaching hospital that has over 900 beds. It is huge! GSH is also a tertiary hospital. The way health care works in South Africa is that a patient goes to a local clinic or day hospital first, then a secondary hospital, and finally the patient is referred to GSH.

GSH has many specialists working with a variety of illnesses, diseases, and injuries. GSH is the hospital where the first heart transplant was performed. I also got to witness a kidney transplant during my time there.

Neurology was the first department I worked in, and I had no prior experience in this area. I learned so much about traumatic brain injuries, strokes, epilepsy, and many other challenges that affect neurological systems. In South Africa there are many traffic accidents, referred to as "MVA's" for motor vehicle accidents. It was very difficult seeing a toddler in a crib with a brain injury having to learn how to eat, drink, and swallow all over again.

I also worked in oncology, both inpatient and outpatient. Although they had radiation and chemotherapy, I began to realize that no matter which department I worked in, I was going to be exposed to death and dying. It was in this department that I saw a patient "busy dying" as they called it, and he was obviously afraid. It really pulled at my heart when I saw his mother holding his hand and giving him permission to die. Yes, I said, "die." It is important for patients and families to say the word because it helps with coping. If we dance around the word, we are not facing the

inevitable reality that may await the patient and the family.

The last month I was at GSH, I worked in maternity. As I mentioned , GSH is a specialist hospital. Therefore, the mothers who came there to deliver had some kind of complication. I saw two 13-year-old mothers; women who had stillborn babies and miscarriages; and many who had high blood pressure, premature infants, and infants born with special medical needs. I did a lot of grief and loss counseling and also witnessed tiny babies growing at amazing rates.

There were interesting things in this department that were new to me. They used cups to feed preemie infants to avoid germs and not allow them to be too lazy to breast-feed. When the infants got to a certain weight...the mothers were encouraged to stay in the hospital to do "kangaroo care." With this method, the mothers kept the infants on their chests to act as a natural incubator.

I had never worked in a hospital, let alone a specialist hospital that sees only the most severe cases. I saw specific illnesses and types of cancer that are prevalent in patients with HIV and AIDS. Each day and each department confirmed for me that I love the medical field. I loved learning about medical diagnoses and terms and counseling patients as they learned to cope with them.

I truly believe that as I begin my career in social work, I will be better for having had this experience. I am much more aware of culture and diversity as well as how fortunate we are to have certain medical treatments available to all people. When I work with patients, I will be more understanding and compassionate.

Michelle Anesu, MSW
Indiana University School of Social Work Class of 2010

Time Out From the War

I was recently invited to do some faculty development work at Tel Aviv University School of Medicine in Israel. One of the faculty offered to take my wife and me on a sightseeing tour of Jerusalem, which we were excited to do. Our first stop was on a hilltop overlooking the old city. It is a favorite stop for tourists and other visitors. As we got out of the car in the parking lot, the view of the city was breathtaking, and our colleague lost no time in describing some of the well-known landmarks like the western wall, the Dome of the Rock, Gethsemane cemetery, etc.

I was listening intently, but what really caught my eye was a group of young Israeli soldiers who were among the sightseers. Although they were in uniform, they were also doing things that were decidedly unmilitary-like. Some were sleeping, others were playing soccer, and still others posing for group photographs. The paradox of a country without secure borders at war and the pleasures of everyday life taken by the men and women who could be called upon to spring into action at any

moment was powerful. This was brought home to me even more the next day in Tel Aviv when three of the eight faculty involved in a small group discussion of mindfulness in medicine mentioned that a child of theirs had been killed in Israel while serving in the army. For me, the scene captured in the photographs is a potent reminder of the freedoms that we and our children enjoy in this country and the importance of being a voice for world peace, irrespective of politics and history. As Gandhi so eloquently put it, we must be the change we most want to see in the world.

Richard Frankel, PhD
Professor of Medicine & Geriatrics;
Senior Research Scientist, Regenstrief Institute,
Indiana University School of Medicine

Teacher

I am the student. I am the teacher. Student is a role I have come to know very well, embrace almost. However, as I progress through my dental school curriculum, I have realized that my role in the community is that of both student and educator.

At the local IUSM student outreach clinic, two dental students armed with little more than free toothbrushes, coloring books, and brochures use education to inform the local community on basic oral hygiene techniques, material on reduced-fee and free clinics in the area, and pediatric insurance available through the state.

Halfway across the world, in a rural outdoor pavilion, a dozen dental students, three IUSD professors, and one local dentist armed with handpieces, amalgamators, curing lights, and syringes treat over 300 children with active caries. The local dentist teaches the professors about fluoridation in the water supply, professors teach the traveling students how to use the lap-to-lap technique, and students teach the local children and their parents the signs of oral infection and pathology.

In both instances, education is the key to making a difference. Working hand in hand with professors and the local community is the only way to truly learn the skills that no text book or lab manual can teach you. Education is the only way to truly make a lasting impact on your patients and their families. Being the teacher and the student in the same moment, using what I have been taught to teach others is a potent reminder that in all aspects of life, knowledge is power.

Katherine T. Nichols, DDS
Indiana University School of Dentistry Class of 2010

Dear Future Katie,

By now, you are likely a highly successful and very important physician. Or perhaps you are a part-time doc who attends all her children's extracurriculars. Possibly, you are both. Regardless of where you are or what you decided to do with your life, I hope that you are pleased with your choices and that you can find your house in the daylight.

I imagine that it will be difficult to remember all the little experiences that helped shape what kind of physician and person you became, so I'm writing to remind you what it was like to be a student. You may well be very busy and have entirely too much to do in too little time. But remember back to your third year of medical school when starting an IV was the highlight of the day? Or when you talked to a patient and uncovered some bit of history that no one else had found? Can you remember the thrill that ran through your body the first time you delivered a baby and how it took a half hour for you to catch your breath afterwards? The students just want to be included and helpful. Talk to them, walk with them, teach them. It won't take much extra time, but it will make a world of difference to those students. Maybe it will make a difference for you, too.

The higher up you are, the more influence you have; make an effort to be a positive one! Be one of those physicians that you wanted as your mentor. To quote one of your favorite sentiments, be the change you wish to see. It may be hard or inconvenient or frustrating, but you have the opportunity to change someone's perspective, to teach them something new, and to make their day better. That makes it worth your trouble. You owe it to your students to be an effective educator. Even more, you owe it to your teachers.

As an aside, if you could let me know what specialty you ended up doing and how the match turned out, that would be great.

Keep reading about your patients,

Katie (2010 edition)

Katherine McHugh
Student, Class of 2011
Indiana University School of Medicine

Medical Professionals, Students and International Partners Working Together to Expand Access to Healthcare Abroad

The Timmy Foundation is an Indianapolis-based non-profit that utilizes the energy of student and medical volunteers to expand access to healthcare and education both at home and abroad. The foundation facilitates medical brigades and channels financial, medical, and human resources to health and education projects in Colombia, Ecuador, Guatemala and Nigeria.

For our medical professionals, the idealistic and enthusiastic approach of Timmy students often serves as a reminder of why they went into medicine in the first place. The interactions they have with our international partners help bring new perspectives to the system and practice of medicine that they know all too well in the United States. It's this form of learning and working together that epitomizes the Timmy Foundation's vision: The people we serve have the ability to live healthy lives and have the promise of healthy futures, and our volunteers carry with them a spirit of humanitarianism and global awareness in their everyday lives.

The nurse in this photo works at Timmy's partner organization, Hospital Tierra Nueva in Quito, Ecuador. She has been working with the Timmy Foundation for almost a decade helping facilitate medical brigades. During medical brigades, M. consults with patients about their diagnosis and educates them about lifestyle choices that can possibly prevent the illness in the future, or at least help maintain it. She has become a great friend of the Timmy Foundation.

This photo was taken in the pharmacy that we set up in the community Santo Domingo de Cutuglahua in Quito. Here, the physician is consulting with M. on treatment options for a specific patient seen in clinic that day. That way the physician, a fluent Spanish-speaker, can get a better idea of the lifestyle of neighbors in the community in order to diagnose and recommend the best treatments for the patient. The photo was taken on the May 2010 brigade to Quito, Ecuador, with students from the University of Colorado and medical professionals from Indiana and Colorado.

Chuck Dietzen, MD
Founder & President of the Timmy Foundation
Indiana University School of Medicine Alumnus

Life and Death on the Nyayo Wards: An Excerpt

The day begins with the call of the ibises, large birds with an unmistakable cry (which gives it its name, *kwarara*). Sunrise is at 7:00 am every day because we are virtually on the equator.

Paradise remains outside as we enter the Nyayo wards. The patients share beds when needed. There is a constant smell of urine, bodies, and smoke. In fact, the smell of burning wood is everywhere in Eldoret, the result of the widespread use of charcoal or wood fires for cooking. The Kenyan huts do not have chimneys, so the inhabitants carry with them the smell I associate with camping trips. The women also risk chronic obstructive lung disease from the smoke exposure. Cigarettes are too expensive for most.

The 30-year-old patient in bed 1 developed jaundice, a leukemoid reaction, and a Virchow's node. Abdominal ultrasound shows a mass near the head of the pancreas. We wonder about lymphoma, given her youth; a biopsy will be done as an outpatient on the off chance that it is a treatable tumor. In bed three, a young woman with AIDS and tuberculous meningitis lies. She is mute, with abnormalities of cranial nerves V, VI, VII, and likely IX and X, as she cannot swallow her TB medications. The orange stain from rifampin on the bed is the evidence. Over the two weeks we saw her, we noted a missing lower incisor ([the result of] a tribal practice of removing this tooth to provide a way to feed patients who subsequently develop tetanus), skin decorations made by making small incisions in patterns on the trunk, a fly larva (probably that of the tembu fly in these parts) emerging from a nodule in her breast, and hyperreflexia that we traced to hypocalcemia (she demonstrated Chvostek's sign). She later exhibited hyperkalemia and hyponatremia that we thought was likely adrenal tuberculosis and Addison's disease of the kind originally described. [Of note, we were able to provide her prednisone (if she could swallow it), but no mineralocorticoid was available in the hospital.] One day we heard the death rattle from her, and she died that night. I will never forget that sound or her face.

Two beds over, a woman with a right ventricular heave and jugular distension visible from the end of the bed is resting. She has atrial fibrillation and hepatojugular reflux. Her heart rate is too fast to interpret her chest findings; but after digitalis and diuretics, we

discern the right ventricular heave, a prominent impulse of P2, a displaced apical impulse, and a palpable diastolic rumble. We have not yet used the stethoscope, but she clearly has advanced rheumatic mitral valvular disease. The ultrasound exam confirmed what we hear and feel; her hope is saving enough money to be seen in Nairobi and possibly undergoing heart surgery.

There are opportunities to diagnose disease with our heads and hands with every admission; we have virtually diagnosed pulmonary tuberculosis in a woman with thrush (therefore, AIDS) and dullness over her right apex. We did blood cultures on perhaps two patients in three weeks. We reversed diabetic ketoacidosis (she smelled fruity) without the benefit of a bicarbonate measurement, and a single, admitting potassium level (we used the ECG to track her potassium). Diabetes care is a matter of extending survival: few patients have electricity at home (insulin is stored in a clay pot filled with water and buried in the ground to keep it cool), and self-monitoring is not imaginable.

The greatest limitation I have is not the reduced access to diagnostic tests, but the inability to take a history myself. One must learn some medical Swahili: *Sema a* (say ah), *Lala* (lie down), *Asante sana* (thank you very much for all I am trying to learn here).

I went to the health centers at Turbo and Burnt Forest with Joe Mamlin and John Sidle. Here is where the battle with HIV is being met. We use a three-drug regimen (lamivudine, stavudine, and nevirapine) available as a combination pill. Think of it: potential control of the disease and recovery from opportunistic infections with two pills a day. As Joe said to me at the beginning of the clinic, "Keep in mind that all of the people you see today were given up to die before this program was started." The great concern at this point is to be sure that all the practitioners in East Africa are using the drugs correctly so that resistance to components of this treatment plan does not develop. The long-term concern is this: we have support at present from the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) via the CDC and USAID to initiate lifelong treatment for 30,000 Kenyans with AIDS. What do we say to patient 30,0001? Of course, the answer is, we will figure that out as we get close.

David Crabb, MD
Chairman, Department of Medicine
Indiana University School of Medicine

Learning Together, Working Together From Legacies

"They believe a new generation of students is where hope is. They look for the opportunity to influence a new generation."

Yvonne Seon, PhD, MDiv

An elderly patient had recently been diagnosed with a terminal cancer. During rounds, we all walked into her room to see how she was doing. I'm sure the she felt a little uncomfortable and scared with 10 white coats walking into the room. While the resident was talking with her, the patient began to cry. At that time the resident held the patient's hand. It seemed the patient just wanted to be touched and wanted someone to talk to. Even though our team was really busy, the resident stayed there and talked with her. The resident did an awesome job of listening to the patient, talking with her, and making her feel more comfortable. The patient and resident ended up hugging. Hopefully in the future I can help make someone feel more comfortable after being given difficult news.

Student, Indiana University School of Medicine

This week on my ambulatory medicine rotation, I worked with a truly outstanding attending physician. I was impressed immediately by his warm welcome to me and I noticed that during the tour he gave me of the building, he greeted all the staff by name—laughing and joking with them about their latest vacations or haircuts. Everyone at this clinic seemed so happy to be there and to be working together, which made me enjoy working there that much more. I also really admired how the attending worked with his patients. He seemed to know a lot about each person we saw and was able to relate to their stories about losing their jobs, selling their plasma to buy medications, or trying to quit smoking. He also almost always managed to make each patient laugh—which further strengthened the doctor-patient interaction. The attending was so genuine with his patients and compassionate about their individual situations without being jaded or judgmental. It was so inspiring to see a doctor really caring for his patients and not simply berating them for not filling their prescriptions or beginning their exercise program. I was really impressed by the remarkable example this physician was setting for me and for his entire staff.

Student, Indiana University School of Medicine

Indiana Medical School, a Great Foundation in Clinical Skills and How to Teach Them

First let me thank my medical school preparation for success during my U.S. Navy internship. During my rotations I found the basic science and the clinical years at IU were exactly what I needed to perform and grow in the practice of medicine with confidence.

After my Navy internship and then Internal Medicine residency in Miami, FL, I received an NIH fellowship in cardiology performed at the University of Miami, then went into private practice in Miami as a non-interventional cardiologist.

About then, a colleague of mine, an anesthesiologist, was teaching advanced first-aid to firefighters. Since I was a young but already well-seasoned doctor in the Greater Miami Heart Association, he asked me to write a curriculum for teaching resuscitative cardiac care, anatomy, physiology, and pharmacology and to help him teach this material to the firemen. I agreed and found the firefighters were eager students. In their words, "Doc, we are tired of holding sick or injured people in our arms, watching them die. Teach us what to do for them."

CPR had just been invented and was in use in hospitals but was not yet being taught by the Heart Association nor the Red Cross. My experience as a med. student at IU Medical Center gave me more than adequate experience to create the required course material and also to successfully interface our developing pre-hospital concepts with the non-medical community, the fire chiefs, the city mayors, the owners of the pro-football team, etc., etc.

From this initial group of about 15 firefighters we established one of the first pre-hospital care systems in the United States. In fact, our group was the first in the nation to have a successful resuscitation of a victim out in the streets. The year was 1968. Like many inventions, similar pre-hospital care systems were being developed at about the same time, but we were plowing new medical ground with these "lay people," the firefighters.

In fact our firefighters were doing things for which there was no legal coverage. From our training and equipping, they were sticking IV needles into people and doing endotrachael intubations. They were giving fluids and drugs, giving CPR in homes and defibrillating without any legal coverage. I wrote and had passed the first statute in Florida to cover our EMTs, Florida Statute # 401, and we all breathed a sigh of relief.

Parenthetically, as part of our development, we talked Southern Bell into implementing the # 911 system for the Greater Miami so our flying squads could be dispatched more readily (1971-'72, I believe).

Jim C. Hirschman, MD
Indiana University School of Medicine Class of 1955

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My attending took us down to Wishard detention to see a prisoner who had come in with a very interesting medical condition and some physical findings she wanted us to appreciate. We students didn't know what to expect in detention, and we were a little nervous when we got there and saw people in leg chains and being escorted by guards. My attending went in to see the patient and talked with him for a while and examined him. She treated him with the utmost respect. She never once made reference to the fact that he was a prisoner, only her patient. When we left she told us that she was having to fight some bureaucratic battles to get him the medical care he needed. I thought it was great that she didn't let anything get in the way of her helping another human being. I am sure that there are instances where it is difficult to see past certain things in order to accomplish this, but I will use this act of professionalism to guide my own behavior in the future, hopefully to be as strong a patient advocate as my attending.

Student, Indiana University School of Medicine

Into Medicine - 1945: An Excerpt of a Memoir

Freshman year was housed in a Bloomington campus science building, the final three years in Indianapolis. Out of college a year, I felt ancient compared to V-12 students rushed ahead at government expense to become World War II doctors in a three-year program; we were the first class back on a four-year schedule. Some classmates were older than I: 46-year-old Captain M. in uniform, retiring from the army; B. and C., thirty-something and changing careers; a few from graduate school or work; second semester a British-born faculty wife temporarily joined us.

First-semester courses seemed immediately relevant and triggered more academic commitment than I had ever felt before. This was the real thing, not mere learning for enrichment fitted around more pressing pursuits like reporting for my college newspaper. Within weeks I knew it was right for me.

Dr. Q., wizened and meticulous, guided us through histology where microscopes revealed tissue wonders. I could imagine translating delicate cell patterns into beautiful fabric. One of the most gratifying revelations was to see what happens to a simple cut; slides demonstrated red corpuscles pouring in, fibrin being laid down, white cells invading, scab forming, epidermis growing in from the periphery. Veteran of many skinned knees and slipped paring knives, I'd always wondered how we heal.

Sexism was not dead, of course. Fourteen of us women started; seven graduated with the class, the others casualties of academics, marriage, diminished motivation, circumstances. Throughout medical school some professors "picked on" women with intense questioning in class or small group, but I accepted this as an amusing challenge, relished a chance to supply correct answers. Freshman year, a classmate confronted me in Science Hall, said I should not be there because I was taking a space better given to a man who "would not marry and leave medicine." I smugly replied that since our class was not full anyway, this was not a problem.

The last two years were a packed blend of didactic and clinical. Indiana prided itself on being "the sixth best medical school in the country" with depth of specialists.

Specialty clinics were mostly in hospitals, occasionally in private offices, "pearls" so inevitable I even tore myself from sickbed to attend. (I later marveled at the wisdom of a screaming

toddler who prevented insertion of radioactive sticks eventually implicated in nasopharyngeal cancer.)

We became alert to pathology around us; on the trolley I spotted a case of "brittle bones," osteogenesis imperfecta (a lady with blue sclerae on crutches); noticed jaundice and premature closure of cranial sutures. Senior year, trios of us went on home deliveries; one Saturday afternoon, I was flattered when a newborn girl was partially named for me—Betty Lou! (Emma, in those days, was a name not to be inflicted on an innocent baby.) Informality and camaraderie ruled; we ate together, worried together, shared cases and lives. We women especially felt "sisterhood."

In 1946 rental rooms were scarce and landlords wary: "We never rent to single women." Finally, family connections brought refuge in a Meridian Street funeral home where, in return for a room, I covered incoming calls when the owners went out. The undertaker and his family were friendly and inclusive, frequently fed me and introduced their interesting friends; but I was home most evening and weekends uncertain when I might suddenly be needed. When a relative visited in January, I was amazed by colorful Indianapolis night lights.

At the end of junior year, I found a treasure, a good used microscope for fifty dollars. That summer I externed (forty dollars a month plus room and board) at Norway's, a forty-bed private mental "sanatorium" in a tree-sheltered, rambling, east Indianapolis Victorian mansion. I drew blood; ran tests in a tiny lab; and did odd jobs such as a run a temperamental (antique) movie projector, operate the switchboard on weekends, and collect fees from families on Sundays.

This job brought much access to patient information, observation of insulin and electroshock therapy (standard then), an array of colorful staff, trained professionals eager to share insights and socialize. When school resumed, the extern job was shared with three others…. Since meals were part of the deal, I kibitzed as G. played bridge in the lounge while we shared contents of a metal lunch box.

My degree represented a goal completed; my entry into medicine had been an excellent adventure. I couldn't realize then what a good lifetime friend I had made: my career.

Emma Lou Sailors, MD
Indiana University School of Medicine Class of 1949

Time Goes By…

i received a handwritten note, via a patient of mine, from one of my physician mentors during my residency…a cardiologist by trade.
i had unfortunately forgotten about him through the years of family matters, medical practice and life in general.
he is now 80 years old.
he is single and has no children.
he is in a motorized scooter for mobility due to a fall, fractures and failed surgery.
he lives in an extended care facility.
he asked me to give him a call when i have a free minute in my busy schedule.
i will.
i bet he is lonely.
it occurred to me from this encounter that time had passed way too quickly for me.

i am 64 years old and yesterday i was 30 years old finishing my training and going into medical practice.
where did the years go?
i still practice medicine on a daily basis.
i still like to do it after 35 years.
i think i still make a difference in the lives of the people i care for…i hope i do.
i am single, alone and still fortunately mobile and intellectual enough to care for myself.
i have a son who is the love of my life…i would do anything for him…and will as long as i can.
the take-home message is the aging of physicians is coming as is the inevitable onslaught of the physical maladies associated with that aging.
those of us who cared for all the others will experience the same conditions they experienced…eventually.

i point this out for the benefit of present day older docs and the bright-eyed bushy-tailed new docs.
keep it all in perspective.
enjoy where you are…day to day.

remember your mentors who taught you the skills you have.
realize that time will take what it decides to take regardless of your best objections.
practice your skills as best you can until you can no longer do so…
be careful to realize when you can no longer do so…
then stop…
and let your students take over where you left off…
they will.

Pat Foley, MD
Indiana University School of Medicine Class of 1972

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It was a Friday afternoon; we had finished seeing all the patients about two hours early and my preceptor had about an hour of dictation to do before he could have been done for the weekend. Earlier in the day, we had started a discussion about hypertension that had never been finished. He could have sent me home and finished his dictation. Instead, he sat me down at a table and proceeded to discuss most everything he knew about hypertension for 45 minutes! I came away from that discussion with such a better understanding of one subject simply because one doctor took the time to be excellent as a teacher.

Student, Indiana University School of Medicine

Student volunteers listen as a patient's case is discussed with the attending physician

The IU Student Outreach Clinic was established by IUSM students in 2009 because they recognized the need for this resource in the Indianapolis community. Today, local doctors and students from all classes volunteer at the clinic on a weekly basis and see patients who would otherwise not have access to care. Because of this clinic, new collaborations have formed between different student and professional groups. For more information and to learn how you can help, please visit http://iu-soc.org.

Henry Chou
Student, Class of 2011
Indiana University School of Medicine

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Concrete. Concrete. Makeshift wood. Concrete.... Hopping up these patched steps to the red doors, over a hundred IUSM students have made their way to the Student Outreach Clinic. We're graciously housed in the Neighborhood Fellowship Church on the east side of Indianapolis, where the student-run clinic's volunteers eagerly come to learn and help a medically underserved community. In fact, the clinic is the quintessence of learning,

teaching, and working together—with students (undergraduate, medical, and pharmacy) and faculty from multiple fields.

Getting started every Saturday morning means getting set up; students from all four years stack up the almost doll-size playroom chairs, pull out the wall dividers, lug up medical equipment, and switch on the lights in the patient rooms. In the adjoining room, the Butler University students set up their pharmacy with a growing inventory of prescription-only medications while the sign-in sheet fills with people who have been waiting since before opening time—patients who need our help.

One Saturday, a middle-aged woman walked in short of breath and with severe expiratory wheezing. After a quick history and physical, the student managing her care quickly set up the Albuterol nebulizer treatment much to her relief.

On another occasion, when a first-year student triaged an elderly woman, she was normotensive and mildly distressed. However, a few minutes later, the student, concerned about the patient's pallor and worsening appearance, alerted a fourth-year. All the signs of an acute myocardial infarction (heart attack) were becoming evident. Soon after, fire trucks and ambulances were at the clinic doors.

Other more hesitant patients have walked through our doors, discreetly requesting STD screening.

Finally, our assurance that we're just exactly where we're needed is when, on these Saturdays, we see a familiar face that has made the long trek back for a follow-up visit.

As the patients share their personal stories and medical histories, our students and staff are able to gather, learn, and then teach. It could be as simple as teaching another student the proper technique to taking a blood pressure or as complex as learning the pharmacokinetics of amoxicillin. And, while we are learning and seeing textbook material, the best part is that we have this exciting opportunity to apply these principles to real patients now. So when a clinic day happens to run long, students don't mind. As one volunteer said, "I always learn something!"

Hannah Choe
Student, Class of 2011
Indiana University School of Medicine

Pay It Forward: An Excerpt

It seems like a lifetime ago when I was a freshman medical student in September of 1972 at the University of Toronto Medical School. As we all discovered, those preceptors and teachers who took an interest in us as individuals became our mentors. It was during our second classroom session of neuroanatomy, the first being an overview of the course and distribution of materials and microscopes and slides, etc., that I became mesmerized by our professor, Ewart George Bertram, MD, whom I know as Mike today. He took a piece of chalk in each hand and drew both sides of the brain at the same time in excruciating detail, including such structures as the zona pellucidum, putamen, external capsule, and all the rest of those weird structures we had never heard of. This exercise only took a couple of minutes, at the end of which he stood back with an expression like the cat who just ate the canary and said we would all be responsible for being capable of doing this by the end of his course. Great; on top of everything else, we had to become ambidextrous. Over that first year, I came to know Mike well as he attended and championed us guys in a lot of our inter-college class team sport matches (football, hockey, lacrosse, water polo, etc.) and joined us afterward in celebration or commiseration of our efforts.

Over the years Mike and I have become hard and fast friends, and I feel he embodies all the characteristics of a great

Mike Bertram, MD (right), and Paul Blusys, MD, Christmas 2009

teacher and mentor that those of us in our profession would dearly love to emulate.

Thirty-eight years after my first freshman medical class experience, I find myself back in the lecture hall with another group of freshmen medical students. However, for the past 30 years of experiencing this privilege here in Fort Wayne, I have not been sitting among the students as a classmate but standing in front of them as their professor teaching Introduction to Clinical Medicine. This year is the first time I have had the offspring of a former freshman medical student as a current student. How time flies!

How different medical school is today. Each student has a laptop at their desk. What resources!: the Internet with instant access to just about everything—virtual anatomy, neuroanatomy, and procedures online at the touch of a keystroke, all in apparent 3-D! There are simulator labs with every imaginable manikin for every imaginable patient.

Times have changed in the theory and delivery of medical education. However, what has not changed is the need for interested and passionate mentors and preceptors. All the lectures, manikins, and Internet will not change the need for one-on-one physician-to-student interaction.

Addendum regarding the title:

The expression "**pay it forward**" is used to describe the concept of asking that a good turn be repaid by having it done to others instead. The concept was described by Benjamin Franklin in a letter to Benjamin Webb dated April 22, 1784:

> I do not pretend to give such a Sum; I only lend it to you. When you meet with another honest Man in similar Distress, you must pay me by lending this Sum to him; enjoining him to discharge the Debt by a like operation, when he shall be able, and shall meet with another opportunity. I hope it may thus go thro' many hands, before it meets with a Knave that will stop its Progress. This is a trick of mine for doing a deal of good with a little money.

Paul Blusys, MD
Clinical Professor
Indiana University School of Medicine - Fort Wayne

Learning Together, Working Together With Our Colleagues

"You cannot teach a man anything; you can only help him discover it in himself."

Galileo Galilei

"We really teach ourselves. If you want to learn, you will always find someone to learn from, be they dead or alive, great or unknown. You learn from everything you see and hear around you—if you are willing to pay attention."

Alexander Volkov

Photograph taken by Meg Moorman, RN; A special thank-you to the IMA's Director of Education, Linda Duke, and her team.

Experiencing the humanities during medical education has become increasingly popular. Art, dramatic plays, poetry, narrative essays, and music can raise awareness of the art of medicine and increase both compassion and empathy. Meg Moorman, RN, Assistant Professor at the IU School of Nursing, and Jeff Rothenberg, MD, MS, lead groups of interested nursing and medical students to the Indianapolis Museum of Art, where they engage in Visual Thinking Strategies (VTS). Using an art object, guided by facilitated group discussion, the students regard the object carefully, convert their observations and thoughts into descriptive words, and actively construct through dialogue a shared "scaffold" of their perceptions. Utilizing VTS appears to increase team building and increases analytical thinking as students "decode" the images observed.

Jeffrey Rothenberg, MD, MS
Associate Professor
Vice-Chair, Faculty Development & Alumni Affairs
Department of Obstetrics & Gynecology
Indiana University School of Medicine

Caring at Christmas

A wonderful tradition started in our dental practice many years ago…one of caring, loving, and doing more to show it.

One Christmas, some of my staff members came to me and asked if I thought there were lonely patients in our practice, especially during the holidays. Even though it had not occurred to me, I knew the answer was "yes." They thought so, too. They wanted to do something extra for these patients who are part of our family practice.

They began to discuss the widow who just lost her husband, a man whose wife had passed way, elderly ones who had no one, and many others. As they compiled the list, more names came to mind. There was the family who had nothing, the sick couple who were caring for each other, and another who was caring for his wife of 55 years who suffered from Alzheimer's disease. By the time they finished, they had 30 homes on the list.

Soon they had a plan: Each staff member would make cookies or candy, buy fruit, bake nut breads, and add many other goodies to a Christmas-decorated plate. It was a perfect gift.

We divided the list and assigned patients to pairs of staff members. Calls were made the day before that we were coming to visit. The next day the staff, dressed in holiday attire, set out in the morning and delivered the gifts of cheer.

The visits were wonderfully received. Some patients

laughed; some cried; others wanted us to stay longer. They were all so happy and grateful. They loved it and the staff was overwhelmed with the success of caring.

That was 35 years ago, and it still goes on each Christmas. We have added a harmonica, a tuba, and an accordion (I play the instruments) during the visits. Some of the staff might sing, dance, and they all just have a good time. The patients clap, sing with us and ask for more.

As the years have gone by, many patients have passed away. [Other new ones have taken] their place. However, the Christmas dedication of the staff to holiday happiness remains unchanged.

To me, it is particularly special because my wife thought up the idea. It is a real gift of Christmas love.

David C Steele, DDS
Indiana University School of Dentistry Class of 1970

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I had the honor of working with one nurse in several junior teaching clinics during my ambulatory rotation. She was extremely knowledgeable about patient care and interaction. She was also a great teacher of technical skills and a great help with the computer. She never complained about staying late and always followed through with patients and updated us on the various test results or other follow-up. She was very insightful and respectful of patients, students, and colleagues.

Student, Indiana University School of Medicine

I was very impressed by the care an attending physician at University Hospital gave to all of her patients. She made sure she knew what type of insurance they had. Then, based on that knowledge, she would prescribe medications on the four-dollar list if possible and would send patients to outside, less costly labs. She was conscientious not to order tests if she didn't need them. Her patients appreciated that she made sure that they got all of the tests they needed as well as their medications with as little financial hardship as possible.

Student, Indiana University School of Medicine

Hope in Full Color

"We have this hope as an anchor for the soul," wrote the apostle Paul in Hebrews 6:19. When cancer patients or their caregivers feel adrift in a sea of concerns and of the unknown, Tina and John Gianfagna step in to give them hope, as well as an outlet to express what they are feeling. The Gianfagnas help them to create bookmarks like these first ones I painted (with inspirational messages beautifully written by Tina) while volunteering with the couple at the IU Simon Cancer Center. I got involved partly because of my experiences when my mother went through treatments for cancer. The Gianfagnas do this because they are seeing to the continuation of the mission and memory of their daughter, Jeanette, who founded the non-profit organization while she herself wielded a paintbrush in her battle with cancer.

Their organization is called Creating Hope—and they do exactly that inside those whose thoughts, fears, and hopes bleed out with the watercolors from the brush as they touch it to paper. As I was painting, John looked up, leaned over to intervene: "Go ahead—put more color on the brush." I continued, peacefully painting, understanding why it is called art therapy.

Carrie Rupprecht
Student, Class of 2013
Indiana University School of Medicine

The Case of the Dysfunctional Eustachian Tube

One of the best things about being a medical professional is the opportunity to solve great medical mysteries. If you love the thrill of tracking down a missing sock or speculating how your friend is able to touch her thumb to her ipsilateral forearm, you're going to love being a doctor. Your own repertoire of interesting cases will grow over the years, but I'd like to share one I encountered this year. This case illustrates the hazards of complacency, the importance of having good mentors, and the necessity of asking the right questions to uncover diagnostic clues.

I met M. during a follow-up visit in the otolaryngology clinic. She was a fairly healthy adult who had been seen several weeks earlier for left ear discomfort and diagnosed with Eustachian tube dysfunction (ETD), preventing her from draining fluid from her middle ear to her nasopharynx. She was given a nasal steroid spray (which should open up her ET and permit the drainage of fluid) and asked to return for follow-up. Unfortunately, her discomfort was still present at this visit, as was her middle ear fluid. I also noted some nasal asymmetry but thought little of it. I presented the case to my superior and, operating under the assumption that this was a classic case of ETD, suggested a trial of a different nasal spray. The doctor confirmed the ear findings on physical exam but then probed the patient about her nose. She revealed that she had been bitten by a dog on the face as a child, which collapsed her nasal valves and henceforth gave her significant breathing problems. Because of my complacency with the prior diagnosis and therapy, I had overlooked this important clue. There was indeed ET obstruction, but it was likely because of a deformity of her nasopharynx, not due to ETD that could have been relieved with nasal sprays. The doctor suggested surgical intervention to correct her nasal passage, which would both relieve her breathing and correct the nasopharyngeal obstruction of her ET.

Although I had missed the diagnosis, my mentor taught me that even a nuance in a patient's history or physical can become the most significant piece of the puzzle. As long as we remain curious about our patients, they are always ready to teach us something new.

Henry Chou
Student, Class of 2011
Indiana University School of Medicine

In our more holistic approach to knowledge, we are not assembled here as a machine, but as a living organism. We have a collective sense of identity and fundamental purpose.

This is the organizational equivalent of self-knowledge—a shared understanding of what we stand for; where we are going; what kind of world we want to live in; and, most importantly, how to make that world a reality.

Paraphrase of Ikujiro Nonaka's The Knowledge-Creating Company, *1991*

Gene Beyt, MD, MS
Clarian Health

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During rounds, we came across a patient wandering the hallways screaming and upset because his stay at the hospital was going to be prolonged. Apparently someone hadn't put in the orders in time for a procedure, so he had to wait another day. Even though he wasn't one of the patients on our team, our nurse practitioner calmly talked to the patient and explained how the process worked and apologized for any inconvenience this might have caused. She then explained she would personally let the patient's team know and reassured the patient that he was going to have the procedure. It was amazing that simply listening to the patient's complaints and concerns (since at that time no one wanted to deal with him because of his outbursts and rage) resulted in the patient calming down. He then thanked the nurse practitioner and went along down the hallway in his wheelchair. This reinforced the important role that simple gestures such as effective communication and caring play in patient care.

Student, Indiana University School of Medicine

On the first day of my third year, I observed my resident discharge a patient. This woman had a history of hypertension and diabetes and was hospitalized with a cocaine-induced MI. While we were talking to her, my resident informed her that she would be discharged on blood pressure medication. The woman looked up and simply stated that she refused to take any pill for her blood pressure.

The part of the encounter that I still think about a month later is my resident's response. She asked the patient, "Why?" and we discovered that the patient had the misconception that anti-hypertensives would cause her to go on dialysis. My resident then spoke with the woman for a long time, explaining everything to the patient, and the woman finally agreed to take her meds as prescribed. This incident sticks with me because I had the privilege of shadowing such an awesome physician. She took the time to interact with the patient as an equal instead of acting superior. I admire her for unraveling the patient's concerns and explaining medical information in plain English. Her approach was very effective, and she gained the patient's respect and trust in doing so. She also gained my respect, and I will always remember the day I learned how patient-physician interactions should work.

Student, Indiana University School of Medicine

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One patient asked my intern and me if we could ask his nurse to help him out with something. We saw a nurse and asked if she could help him out. She gladly went in to help our patient. Later we found out that she was not even our patient's nurse but helped him out despite this. She could have easily told us no and to find his nurse to help him. She truly embodies what professionalism means in putting the patient first no matter what.

Student, Indiana University School of Medicine

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If you would like additional copies or to submit a piece for future *Reflections*, please call or e-mail:

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