
RHODE ISLAND MEDICAL JOURNAL



SPECIAL SECTION

PROGRAM *in* LIBERAL MEDICAL EDUCATION, PART I

GUEST EDITOR JULIANNE Y. IP, MD

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Overview of Brown's Unique 8-year Program in Liberal Medical Education (PLME)

JULIANNE Y. IP, MD
GUEST EDITOR

I am guest editing this month's and next month's editions of the *Rhode Island Medical Journal* (RIMJ) because I felt the need to share with the greater RI medical community some of the lesser-known aspects of Brown University's eight-year baccalaureate-MD program, the Program in Liberal Medical Education (PLME) and the Alpert Medical student's journey into medicine. As the Associate Dean of Medicine for PLME, I have the privilege of interacting with these students for eight years – the most formative years of their lives. I have included works that are scientific, reflective and creative from the PLMEs as well as Alpert Medical students who entered via the “standard route” of admissions.

This effort is dedicated to former Dean of Medicine David Greer, MD, whose vision created the PLME. His passing was a great loss to medicine, society and many of us personally; may this tribute be fitting of his legacy.

First, a brief history: in 1985, Dean David Greer and the then Associate Dean of Medical Education, Stephen Smith, created the PLME. They wished to accept the “best” high school students who would utilize Brown, and the College's unique Open Curriculum to craft their own educational paths. These individualized educational plans would allow students to pursue their passions be they in science or liberal arts but always with the view of medicine as a humanitarian pursuit, not a “trade” to be learned. Each PLME has always worked with an adviser to choose courses as well as activities during the academic year and summers that would allow them to fully develop personally, academically and professionally.

I focused on three specific areas to highlight in this edition of the RIMJ: first the “liberal” aspect of the PLME, through our special courses, preclinical electives, creative writing and reflection. This section culminates specifically with a piece from the Student Health Council which often helps students as they delve deeply into being a healthy, well-balanced, future physician. One of Brown's core competencies has always been self-awareness and the ability to develop professionally and these pieces are a small representation of how our students find their values.

Next, in Part 2 in the August RIMJ, I provide a current synopsis of our Brown medical international “exchange” programs. Dr. Greer was very active internationally as he felt the United States could learn a great deal from other nations. He was recognized with the Nobel Peace prize for his international work. And finally, I have included

scientific research pieces that our students have written highlighting another core competency, lifelong learning. All Brown's PLME and AMS students are intellectually curious, strive for academic rigor and look to solve ongoing problems in the world. A quick note: these pieces were all voluntarily submitted when I sent out a general call for student participation. These are not necessarily representative of all the students' work but those who chose to share.

As the AMS and PLME strive to provide opportunities to broaden our student's perspective in caring for their patients, there are specific pre-clinical electives and now a new PLME course: Creative Decision Making, for students to take. The Creative Decision Making course is co-lead by one of our dedicated Medical Humanities faculty, Dr. Jay Baruch. He partnered with Rhode Island School of Design Museum Curator and Educator, Hollis Mikey, first in offering a pre-clinical elective in Medical Humanities and now a full-fledged course, Creative Dimensions of Medical Decision-Making, whose expressed mission is: to “think about how we think...to reflect on our habits of mind — how they shape our perceptions, interpretations, and critical decisions. Even in circumstances of complex problem solving, we are frequently unconscious of how and why we make the decisions we do; the assumptions made, the cognitive shortcuts taken, the narrative structure imposed.” Emphasis will be placed on examining “Uncertainty and mystery which are critical dimensions of medicine. Rigorous out-of-the-box thinking and reflective skills which make for efficacious diagnosis and treatment cannot be acquired by leafing through books or staring at the pixels of PowerPoints; thus students will engage with creativity as ways to meet the challenges of medical practice.” This and other medical humanities efforts are supported by Dr. Fred Schiffman and our local Gold Humanism Society chapter and Brown's Creative Arts Council, from whom I received a grant in support of the course.

This course follows the fall semester PLME senior seminar which is an interdisciplinary and integrative science course that supplements the preparation of PLME for the study of medicine in the 21st century. The PLME Senior seminar which I lead uses a case-based approach to relevant

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and contemporary subjects in medicine and health care, such as biological systems and their interactions, mechanisms of intra- and intercellular communication, drug therapy optimization, and humanistic aspects of patient care as well as addressed the social, behavioral and ethical contexts of health care in context of health care economics. One of the most important parts of the course is narrative reflection. As the course leader for this class, I highly encourage our students to be self-reflective and approach medicine empathically through these reflections. The first writings presented here are three reflections for the semester. After the student's submit, I respond to each student individually pushing them to think more deeply, challenging them and encouraging them to shift from their own lifelong learning to caring for patients. Our Associate Dean of Medical Education, Dean Allan Tunkel has been extremely supportive of these efforts as was former Associate Dean of Medicine Philip Gruppuso.

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Poetry of PLME, AMS Students

The following poems express the creativity of The Brown Program in Liberal Medical Education Program (PLME) and Alpert Medical School (AMS) students.

RADICAL. 2007, August

MARA FEINGOLD-LINK, MD'17

*"In 1980 the patient suffered from a right breast carcinoma.
A total mastectomy was done, possibly a radical mastectomy."*

Radical: of or going to the root or origin.

Radical: thoroughgoing or extreme, especially as regards change from accepted or traditional forms

Radical: favoring drastic political, economic, or social reforms by direct and often uncompromising methods

In 1980, radical feminist Audre Lorde, (Radical feminism: a movement based on the belief that the power structure in society is the diffuse and male-dominated patriarchy, which works to oppress countless populations and individuals, including all women) published her memoir, *The Cancer Journals*, about her experience with breast cancer, from biopsy to mastectomy.

(Radical: losing a part of one's body.)

Lorde describes in detail

her vicious pain and the

excruciating process of recovery.

(Radical: speaking openly about one's body.)

(More radical: a woman speaking openly about her body.)

(Even more radical: a woman speaking openly and simultaneously about the pain, ugliness, horror, beauty, strength, and love of her body.)

That same year, Janice Robertson,
who had never heard of Audre Lorde
and would not have called herself a feminist,
found a lump in her own breast
that the doctors decided was malignant.

Her current doctor writes that she underwent
a radical mastectomy,

(Radical mastectomy: surgical removal of the breast,
underlying muscles, and lymph nodes in the axilla.)
maybe.

(Radical: that neither the patient nor her doctor knows
for sure what surgery she received.)

Post-surgical checkup:

What is the origin of the pain? asks the doctor.

The patriarchy, answers Audre Lorde.

I don't know; it's all over, answers Janice Robertson.

Can you point to it? asks the doctor.

I wish, answers Audre Lorde.

I wish, answers Janice Robertson.

WHITE

ALEXANDRA WONG, PLME'18, MD'22

I hate white.

Paper.

The blank sheet in front of me mocks me, daring me to write something on it. Daring me to destroy the innocence, the purity of that flawless white. Daring me to besmirch perfection with the abstract smudges of graphite, or the dirtying blots of ink. Daring me to write something of worth – something worth butchering trees, something worth bleaching their natural splendor.

Snow.

The blizzard storm outside the window stops me, masking everything from my sight. Masking the warmth of a fire, the vitality of those flickering tongues. Masking the golden glow of the sun, or the silver shine of the moon. Masking anything of worth – anything worth seeing, anything worth noticing at all.

Four months ago, I never would have thought that I'd have to choose life or death for another person. Four months ago, I would've avoided this white, sterile room, this white, sterile bed, this white, sterile blanket.

This white, sterile person.

The blood is gone from his cheeks, once rosy and plump. The sparkle is gone from his eyes, once innocent yet penetrating. That was before a freak spell bubbled inside of him. The glow is gone from his skin, once radiant but soft.

Now, those specialists, resplendent in their white, clinical lab coats present me with a choice. A choice of life or death.

When I had my son, I was prepared. Prepared for the sleepless nights, the accidental magic, the energetic babbling. Prepared for the hair-color changing, the rebellious teens, the exploding food. I was happy to take those responsibilities. The bad came with the good, and I could find balance.

But this? The choice to encase him in a white, plastic tomb, still breathing, or to seal him into the earth, not breathing? What kind of a choice is that?

One spell. That's all it took: to seep into his veins and immobilize his nerves, throwing his natural chemical reactions into chaos. "Magic is just directed energy," they told me. I'm not stupid, I told them. Give me the science, and don't patronize me.

Silver-rimmed glasses slid down a nose, the eyes above it evaluating me. "Magically induced comas result from the blockage of the electrical signals of the nervous system. There are two types of such comas: one from an energy 'force field' blockage, the other from the disruption of electrical signals." He paused. A white, arched eyebrow. Continue, I said, my voice dead.

"Theoretically, to destroy the coma, you would break the force field or absorb the energy disruptions. But there aren't any therapies for that."

None? I ask mockingly, looking at this sheet of paper in front of me. No research papers published on the topic, their words and words of black meaningless?

"This spell," the white-haired man in front of me frowns.

"It was painful. Spells like these augment the both the hormonal and electrical signaling in the nervous system.

The magical energy tends to prefer the electrical side by exciting the electrons, although it also adds to the activation energy for the binding of neurotransmitters. Unfortunately, this spell wasn't developed well, so the curse isn't very stable. The magical energy wasn't a concentrated, controlled emotion, like normal incantations. With all of that extra magic bouncing around inside of him, it was almost a form of radiation, and it spread all across his body."

What do you get, when you combine radiation and spreading?

The dull beeping of monitors replaces the cracks of gunshots. Chemotherapy drugs and radiation treatments replace the last resort of the hydrogen bomb. The cancer cells are the terrorists, and the hospital bed is the battlefield.

Cancer.

That white tumorous mass. Growing inside of him, sucking out the warmth from his blood, the strength from his muscles, the life from his body.

The light from his eyes.

One cell. That's all it took: to replicate unregulated and

spread across his limbs, destroying every healthy part in its path.

When I learned of my son's powers, I thought that magic could solve everything. With a muttered incantation, it should have evaporated the tumor in the blink of an eye. Apparently, magic doesn't work like that. Not biologically.

What use was magic, then?

What choice is this?

Four months, the specialists gave me. Four months that he could run around, smashing his toy cars together and smiling that beautiful baby smile. Four months for him to chase the blue jays flitting about our backyard, to inspect the creatures dancing on the water's surface in our neighborhood creek. Four months for me to say goodbye.

Three pieces of paper for me to read. Three pieces of paper to sign.

Two days to decide to keep him on life support, or to let him go.

Let him go? How could you possibly ask a mother to let her son go? When he's just begun his life, his new eyes barely taking in the rainbows of colors and shapes in the beautiful world we live in? When he hasn't learned the pressures of middle school, the pains of a broken heart, the happiness of a healed one? How could you ask a mother to snuff out her child's life? How could you?

How could you?

One signature, and it was done.

One name.

Bianca.

They unhook him from all of the machines, removing the tubes that kept him entangled in this white, barren battlefield.

It took three breaths.

Two blinks.

One smile.

Snow.

And yet, the flakes of water sprinkled across your eyelashes can be the most delicate blur to see. A perfectly ordinary substance changed, sculpted, assembled. A crystal, flawlessly formed with its microscopic beauty, and its sparkling structure.

Paper.

And yet, the dark symbols on a piece of perfect paper can be the most satisfying work to see. The culmination of hours of emotion, of heart, of soul. A bubble, capturing the very essence of a person's existence, or a person's imagination.

I hate white.

MATTERING

ZOE WEISS, PLME'12 SCB HUMAN BIOLOGY
AND AB ANTHROPOLOGY, MD'16

I think I've forgotten how to write.

Poised above a keyboard reaching for just one of
a dozen thoughts each darting by –

gray and intangible,
as if my focus could not
— hold —

to capture even a single frame.

So here I am, armed with a *third* cup of coffee,
a pile of half-opened deliberations
creased into bookmarks, tucked into a wide white pocket
writing about how I cannot write anymore.

My fingers — charmed into self-assurance
Tracing intersecting stains into perfect rings
As if to *reassure* the wood

It's not that I used to have such profound thoughts
and suddenly have deadened.

On the contrary
they were *more-often-than-not*
tritely existential, too proudly compassionate
written with the candor of a young scholar balancing
cynicism, optimism, and reason,
Animated by the notion that I may consider what
does or doesn't matter,
about the meaning of mattering,
and the *mattering of mattering*.

Until I have been immersed in mattering,

By a role most inconsequential.

Un-pretty-un-poetic- awkward-flustering-
nearly-always-lost

Watching the rise and fall of a rounded baby belly, shaken
into cerebral oblivion,

jarred by the shrill of the monitor remembering

Awed by toddlers whose bones break and bend and bruise

Begging for a sticky purple popsicle

Who become children chasing cars into streets and out of trees;

To teenagers whose dark eyes cast nooses as they roll,

Into young mothers, hair pulled tight,

Too thin or too thick, painted with worry,

lipstick, and cigarette smoke,

A sleeping number to the hip, another tugging,
screaming at her shirt,

Dulled by paint chips, cockroaches

coughing on air heavy with smoke and
smog and violence.

I think those are things that matter.

But here I am, and wordless, paging through manuals

Dense with impressive language, surely

I should find a formula,

Highly regarded, double blinded, multiphasic, systematic

Explaining this hierarchy of mattering

Fashioned from rules spun by egos, debt and deprivation,

Transiently occupied by people named "the ruptured
spleen" and the "epidural in room two."

Here is where I begin forgetting.

Reflections from Students in PLME Senior Seminar, Doctoring Courses

The first reflection based on a prompt in the PLME Senior Seminar asking students to “think about when they or a family member may have been a patient.” The preceding classes were breast cancer-related with genetic testing, choices about treatment if BRCA genes were identified and included a patient panel discussion with patients presenting their perspectives on their choices. After reading the submission, I would use the opportunity to send back comments and additional questions. For Eric Bai’s reflection, for example, I would ask about “empathy” and how a physician might have addressed his family’s needs. I would ask about cultural competency and how the US health care system might have integrated some traditional Chinese medicine into the care of his grandfather and finally, I would ask about Eric’s reaction to dealing with death and dying.

PERSONAL REFLECTION ON END-OF-LIFE CARE

ERIC BAI, PLME’ 16 SCB COMPUTATIONAL BIOLOGY, MD ‘20

Earlier this year, I saw how difficult it was for the doctor, patient, and family to decide not to proceed with treatment for a terminal condition. When I went back home last winter break, my grandpa (my mom’s dad) had just checked into a local hospital a few days before I arrived, after weeks of a weak appetite and worsening jaundice. The doctors do an MRI and find two suspicious nodules in his pancreas. They operate a few days later and find late-stage pancreatic cancer. His symptoms are a result of the tumor impinging on neighboring vessels.

Everyone in my family, especially my grandpa and mom, takes this news with a businesslike trust in modern science. They had seen how much allopathic medicine worked – how “there was a pill for that” – and, coming from the spotty medical care of Communist China over twenty years ago, had spent their lives building trust in this paradigm. My mom wants to find “the best” treatment through whatever means possible, but it is very difficult since we were nearing the no-man’s land between Christmas and New Year’s. Somehow, we land an evaluation at City of Hope, one of the biggest cancer specialty hospitals in our area and also the closest out of all of our options, a few days before Christmas. And they take Medicaid. We think our luck has turned.

Grandpa is discharged from Whittier Hospital and, on the drive over to City of Hope, my mom talks on and on about all of the new treatments available for these types

of invasive cancers, throwing around phrases like “radiofrequency ablation” or “targeted therapies.” We get there, sit in a wonderfully sterile waiting room, and, a few hours later, find ourselves in a sun-filled exam room with a young Asian-American oncologist probably no older than 35. He speaks a valiant, if somewhat broken, Chinese and, on this foundation of a fluctuating language barrier and hope bordering on desperation, the conversation begins.

My mom clutches her paper filled with notes carefully transcribed from a phone call with a doctor-friend. She methodically runs through a list of possible options – what about X for his constipation? How about Y for appetite? Can we do Z to see if the tumor can be reduced? She looks over at me with a hopeful smirk: “I am a patient advocate who knows what’s up and we are going to get this all sorted out.”

My grandpa speaks no English and has only one question: “What can I do to live?” He says that he’ll do anything, even chemo. Ever since I was very young, he’s been afraid of dying. And so he pushes the question and my mom willing and gladly translates. She adds on all of the new therapies that she read about online earlier that day.

The oncologist looks thoughtful and starts laying out some options: “Don’t rush. We have to see the best course of action.” He seems to be the model of good physician behavior: he listens, answers questions, and addresses concerns. But he does not offer any of the guarantees that we are looking for. Nevertheless, he agrees to check my grandpa in that very same day.

So begins the long penultimate stay. Some combination of my dad, mom, sister, aunt, grandma and I take shifts at his bedside. We go in the morning. Another crew goes in the afternoon. My mom takes a few months unpaid leave from work. We bring him porridge, some preserved vegetables, chicken soup. We go hunting for fucoidan at all the local vitamin shops, because that’s what the Chinese newspaper says cures cancer. We find it on Amazon and do next day. We give him 6 pills of fucoidan extract and a cup of lingzhi mushroom extract each day. Grandpa is restless and too independent. He doesn’t listen to his nurses. He scares them.

After a week of procedures and tests, we go to the hospital in the late evening, around 4 p.m., to meet the oncologist for the final report. He and my mom stand outside of grandpa’s room. He starts talking and the first two words that come out are, “I’m sorry.” Bad news. You can see the realization

dawn on my mom. Her eyes dim. Her shoulders sag. But she continues to nod graciously and starts asking about next steps and what the handoff is going to be like. Ever the knowledgeable consumer.

The oncologist then goes into the room to break the news to my grandpa. Armed with his broken Chinese, he starts talking about quality of life and how chemo at such an advance age and state of disease would do more harm than good. My grandpa grabs the doctor's hand and begs for chemo. He says no. But my grandpa won't let go. This was one of the hardest things to watch.

And so he is discharged from the hospital and gets transferred to a hospice in Whittier a few blocks from Whittier Hospital, where he started this journey and where my sister and I were both born. They say he has one more month to live. They take him off all of his medications. Palliative care they say. He just needs to be comfortable. Stronger painkillers. His feet are grossly swollen. They lift them up to help the fluid flow out. My mom is concerned that the nurses aren't giving him enough attention. She puts up notes all around his room instructing the nurses on what to do. We go one morning and find him shivering without covers next to an open window. My mom is furious and we bring our own blankets. He doesn't eat much anymore. He gets fainter. He used to hold our hands when we went to see him but now,

just a few days later, his eyes are blank.

Zheng Zhi Bo passed away at around 1:12pm on 1/12/2014. His room number is 112. He is a few years past 90. All told, this process goes from 12/19/2013 to 1/12/2014. Just 25 days. He is peaceful, no longer in tremendous pain. And we are glad to see him go.

My mom still somewhat clings to her alternative histories. If only he had been transferred to a higher-level facility sooner. If only his damn family physician had been more mindful of his complaints earlier. If only the nurses hadn't forgotten to cover him that morning.

For me, I can't know any alternative histories and the matrix of interactions is too complex for me to trace any meaningful trail of blame. I think about how difficult it must have been for that oncologist to say no, show restraint, and turn away in the face of such an eager, willing, and determined patient. I think about how my mom looked everywhere for sources of information to know how to proceed in the face of a condition that worsened by the minute. I think about what it is like to work in a place where people go to die. From this all, I know that restraint, patience, attention, and empathy are gold-star traits of a good physician. We can't predict what might be different, but we can listen to work towards the most humane outcome.

Reflections from Doctoring Courses

Similarly this type of reflection is submitted by students in the Doctoring courses year one and two of medical school. Each small group has a physician and a behavioral science faculty who similarly respond to the narratives. This student reflected on the "Check Lists" that the Doctoring course uses to help students with taking medical histories in a complete and orderly fashion.

Reflection for Doctoring: "You come to medical school like anyone else." (A reflection on lists) As a Doctoring small group leader, we are asked to read and respond to our students' thoughts on medicine and medical school. While I was not Sarah's small group leader, if I had been, I might have taken the opportunity to push her to think more about "death" and how she was dealing with it based on her writing about her cadaver. I might ask her if she thought she "belonged" in medical school as so many students have doubts about this early on...and perhaps I would ask her how she was going to take care of herself as she progressed on her medical educational journey.

CHECK LISTS AND THOUGHTS IN THE ANATOMY LAB

SARAH MAGAZINER, MD'19

There is a unique, somewhat arbitrary transition that occurs when a person is accepted into medical school. I remember, for example, the concern people had for my significant other during revisit weekend when we spent an hour in the anatomy lab peering into open chests, cradling various organs and limbs, and admiring the superior ventilation system. The assumption seemed to be that since my partner had not gone through the motions of a pre-medical student he was somehow less equipped to handle the sight of a cadaver – that the act of being accepted into medical school had automatically elevated the rest of us to a level of preparedness to deal with the complexity and intimacy of the lab and its contents, prematurely setting us apart from those *not* destined to be doctors.

The weekend was punctuated with moments that illuminated this hazy distinction and made me feel as if I had crossed an invisible threshold. When an admissions officer read aloud a list of impressive facts about the newly admitted class, I felt like I had only just been pressing my nose up against the glass, peeking into a world that I hoped to gain access to, and now I was magically on the other side and the people they were describing were my peers. I had somehow

made my way onto the admitted list, and I am continuously reminded that it is a highly privileged place to be.

In our Doctoring course we have been taught a list of questions to ask regarding a patient's chief complaint and the history of their present illness. And each day when we enter the anatomy lab, we are presented with a list of structures to find, accompanied by beautifully precise diagrams with color-coded labels. In either case we are told beforehand that the reality won't be anything like the books and there are moments when I realize that the list can't apply and the lines grow blurry and panic sets in: the veins aren't blue and the arteries aren't red, the structures are abnormal and the questions need to be modified because the patient isn't complaining of physical pain, she's worried about weight gain so on a scale of one to ten her pain is...different.

And in real life, my pain is different, too.

My most recent position didn't make it onto the highlight reel of profound accomplishments, prestigious jobs and exotic experiences, and it certainly can't be found on a list of pre-medical requirements. That is because the last job I held before coming to medical school was that of a full-time patient. I have accrued my own list of experiences and questions; my own private tally of fears, scars and discomforts. And like the infections that invaded my body, they remain invisible to the outside world. I often wonder if my ability to fully feel like a medical student is at all compromised by the fact that I have lists of medications to take each day, that I still spend a considerable amount of time in the doctor's office receiving treatments, or that I identify much more with patients than I do with doctors. As I get to know my classmates and start connecting faces and personalities to the impressive resumes, in my mind, the patient version of myself still cowers behind the glass feeling slow, clumsy and self-conscious about all the healing I have yet to do.

The more I get to know my new peers, it is not hard for me to understand why this group that I am now a part of is one that commands respect and responsibility before we have even truly earned it. Yet, as Robert Lowell points out in his essay *The Body of Strangers*, given the lack of "any real change in our abilities to help people," this transition represents a sudden inheritance of "more power than is yet deserved," and an expectation of "readiness" that others are not assumed to possess.

Writing this reflection only hours after removing a human heart and holding it steady while my classmate sawed through it, I remain humbled by this reality and increasingly aware of the parts of me that linger behind the glass, looking in at my current self. I admire how convincing I look in my scrubs, scalpel in hand; hear myself rattle off the names of the nerves in the posterior mediastinum; watch as I inspect what my classmate calls a "crazy looking tumor" on the lung of the cadaver on the next table. But I also think of my own experience with the grueling uncertainty of illness and wonder, as we sort through her insides, if we are addressing any of *her* unanswered questions; if this intimate vantage point

sheds light on how she struggled in her final days. I see the slight shudder that goes through me when I glance past the gaping thoracic cavity and catch site of the cadaver's arm. I am reminded of my grandmother's soft papery skin and have the fleeting thought that maybe I should cover the cadaver up so she doesn't get cold. I think of her family, surrounding me in my position behind the glass, and have the urge to protect them, too. And I realize that my preparedness for this particular task is not intrinsically linked to how much I can separate myself from my humanity, how fully desensitized I can become, or to what extent I can repress my identity as a friend, a member of a family, or a patient. In reality, the glass is a mirror and the parts of myself that feel at ease in this environment are not that separate after all from the parts that remain fearful and uncertain, or even sick.

In fact, I think they need each other.

I expect that one of the more fulfilling aspects of medical school will be fostering these different parts of myself while accepting that they can, in fact, co-exist. I anticipate coming to acknowledge the hidden vulnerabilities that lie within others, appreciating the abnormal structures I encounter, and embracing any and all deviations from the lists. If it comes to a point where I struggle to do so, all I will need to do is hold up a mirror.

In the Doctoring Course, students may use the opportunity to reflect and try to make sense of their "past" lives as they journey into becoming a physician. The following three submissions are from another from medical students either reflecting or writing creatively to help themselves meld their personal and professional lives.

REFLECTIONS ON BEING A DOULA

KIRA NEEL, MD'18

Whether the parents-to-be I sit across from are 16 or 35, most conversations start with relatively blank stares and the question, "so...what exactly does a doula *do*?" Some women hear about doulas from friends who have used one, or from magazine articles, while others may learn about doulas from their providers, or pregnancy books. Continuous labor, delivery and postpartum support in the form of a birth doula is becoming more common as the positive benefits to birth outcomes become more widely known; yet doulas are not available to everyone. Doula services are generally paid for out-of-pocket and can cost anywhere from \$400-\$1,000 in Rhode Island. Relatively speaking, compared to the total cost of a hospital delivery, this is not a lot of money, but for many families, the cost is prohibitive. In response to this, national organizations, such as Health Connect One, train and provide community based doulas free of charge to low-income women.

I moved back to Providence in the fall of 2013 after years of working in the theater, and as a doula, in New York City. Upon my return, I reconnected with a mentor who asked if I was available and interested to attend births *pro bono*. I was! The first birth I attended was for a woman whose partner was incarcerated. Throughout labor – between meditating during contractions, receiving an epidural, eating containers of jello, sleeping, telling stories, and texting to remind her kids at home to do their chores – she received regular collect calls on her cell phone from her partner in prison. She kept him updated on the progress of her labor. They cried together sometimes; he consoled her, made her laugh and told her the sorts of sweet things we all hope our partners will say during labor. He told her he believed in her, he apologized for not being there, and yet, he was there, as best he could be. Late that night, she delivered their son vaginally, gave him the name they agreed upon, and began breastfeeding.

After delivery, birth doulas have an additional postpartum visit with parents and new babies at their home. We take that time to tell the birth story, process any remaining questions around the birth, and check in on how the transition home is going. I visited this mom for our postpartum visit on Halloween night. Her elder children were out trick-or-treating, and she was at home with her newborn baby. She shared the challenges of this initial postpartum period – she felt isolated, needed help with breastfeeding, missed the company of other adults, and was generally exhausted. Her sense of isolation was exacerbated due to the absence of her partner, but her feelings of exhaustion, struggles with breastfeeding and missing adults is common with many new moms I've worked with. I tried to connect her to services and mom support groups, but when I heard from her a few weeks

later she had stopped breastfeeding and sounded resigned to making the best of her situation. (Since that time, there is now a Baby Cafe in Olneyville, and another slated to open in the summer of 2015 in South Providence, which is a great resource for pregnant and new moms seeking breastfeeding and social support).

As I transition into medical school, I continue to work as a doula whenever possible. In early 2014, Gina Rodriguez-Drix, Jennifer Rossi and I started the Doula Collective to expand access to free doula services in Rhode Island. We currently provide free doula services to teen moms, in partnership with the Nowell Academy, a charter school in Providence and Central Falls, specifically designed for pregnant and parenting teens.

I am excited to share my experiences and training with my medical school classmates. In the spring of 2015, the Doula Collective will be leading a workshop on doula care with Brown medical students thanks to a Petersen Fund grant from AMS. Lessons learned from my experiences as a doula are invaluable in shaping my vision for what it means to be a doctor: recognizing the importance of community-based partnerships; acknowledging patients' emotional responses to physical processes; navigating the boundaries of being emotionally present and holding space for a family while not making the process be about me; and learning how to take care of myself while on call, during labor, and after a birth. I am so thankful for the trust my clients have put in me, and grateful for the opportunity to be able to share my skills with the Providence community. It is my hope, and that of the Doula Collective, that, moving forward, we can create enough awareness of and access to doula care that the question of the future will instead be, "Hi. So, who is your doula?"

The 'L' in PLME: A Broad Approach to Medical Education

JULIANNE Y. IP, MD

The "L" in the PLME stands for Liberal and we strive and encourage our PLMEs to have a broad-based liberal education with the underlying pedagogy that medicine is practiced in the real world. Students need to have an understanding of economics, political science, social and behavioral science as well as the humanities. Music and art bring cultural understanding and humanism to the practice of medicine. The AMS also offers "Pre-clinical electives" covering an array of topics including but not limited to: Complementary and Alternative Medicine, through Biotechnology or Informatics in Medicine, Fetal Medicine, Wilderness Medicine or Opera and Medicine.

The following is a final paper from the Opera and Medicine elective. This elective as with other medical humanities electives pushes our student to "think out of the box" and experience the human condition as others have throughout the ages, through the creative arts.)

DULCAMARA THE DUNCE: PERCEPTIONS OF PHYSICIANS IN L'ELISIR D'AMORE

DILUM ALUTHGE, PLME'15 SCB APPLIED MATHEMATICS, MD'19

Before the advent of the germ theory of disease, and other such seminal discoveries in medicine, those who occupied the role of physician in Western society generally had no effective medical care to offer their patients, instead relying on placebos, superstition, and "treatments" (such as bloodletting) that often did more harm than good.^{1,2} Because of this inability to properly treat patients, physicians of the time were often seen as incompetent and self-serving. These perceptions manifested themselves not just in society but in the various works of art produced during the time, such as operas. An excellent example is Donizetti and Romani's 1832 opera *L'Elisir d'Amore* ("the Elixir of Love"). Examining the portrayal of Dr. Dulcamara in Act I of *L'Elisir* reveals the underlying perception of physicians as self-indulgent and fraudulent.

Romani's libretto spares no effort in depicting Dulcamara as pompous and self-indulgent. Indeed, the first time he appears on stage, Dulcamara is being "drawn on in a gilt chair" as his attendant sounds a trumpet.³ As the peasants gather about, Dulcamara shows no modesty, introducing himself as "the greatest, wondrous benefactor, a doctor [without equal]," whose renown is "known the wide world through." As if that isn't enough, Dulcamara goes on to

explain how he brings happiness wherever he "deign[s] to call," thus reminding the peasants of the elevated station he holds above them. All of these excerpts from the libretto serve to firmly establish Dulcamara is incredibly pompous and arrogant. And various stagings of *L'Elisir* often go further, supplementing the libretto with additional details designed to solidify this perception of physicians. For example, one staging portrays Dulcamara as very overweight, and dresses him with frills, fancy coats, and excessive jewelry.⁴ This further solidifies the perception of Dulcamara (and by extension, physicians of the time in general) as pretentious and self-indulgent. But self-indulgence is not the worst of Dulcamara's flaws; the doctor is also portrayed, in no uncertain terms, as a fraud. To the villagers, Dulcamara promises limitless benefits; he can heal any ailment, improve any disability, give youth to the young. In his own words, upon taking his medicines, "all evils are at once upset."³ The deception does not end with this general purpose scam. When Nemorino (the opera's protagonist) asks Dulcamara if he sells a certain love potion (the "amorous drought of Queen Isotta"), Dulcamara claims that he certainly does (despite having never heard of it) and improvises, selling Nemorino an ordinary bottle of wine. When Nemorino inquires how long it will be for the potion to take effect, Dulcamara tells him one day, which as he explains to the audience is enough time for him to leave town. One staging further enhances this last point (the picture of Dulcamara fleeing town before Nemorino realizes the deception) by having Dulcamara and his assistant begin rapidly packing up the cart once Dulcamara has sold the "love potion."⁴ Altogether, these various deceptions, as portrayed in the libretto and various stagings, firmly establish Dulcamara as a fraud and a charlatan, a reflection of society's latent frustration with doctors that, due to their lack of expertise and tools, fail to deliver on any promises.

Given the substantial progress made in medicine since the 19th century, one would expect that perceptions of physicians have changed dramatically. While change has indeed occurred, there are signs that some threads of the same frustrations persist in society today. Popular television programs such as *Family Guy*⁵ and *30 Rock*⁶ feature physicians (Dr. Elmer Hartman and Dr. Leo Spaceman, respectively) that are laughably and outrageously incompetent. And small-scale surveys seem to indicate that the perception of doctors as primarily driven by money is far from absent today.⁷ Finally, and perhaps most interestingly, a recent study in the

International Journal of Obesity found that patients were less trusting of doctors that were overweight, and were less inclined to follow their medical advice.⁸ These signs imply that the perception of doctors as self-indulgent, incompetent, and fraudulent may be more prevalent today than we care to admit. Although physicians may no longer be selling wine to patients, in a way, Dr. Dulcamara lives on today.

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The quintessential part of reflection, however, is how to process and manage one's values and stay well. The following two submissions are based on "wellness." We have a very strong commitment to our students "self-awareness" and put many support programs in place to help them deal with the stresses of medical school: not only the volume of material that has to be learned coupled with constant assessment. This stress in itself would be enough. But having to deal with death initially through the anatomy course and their first patients, their cadavers, onto their Doctoring patients and the stories the patients will tell them. The submission by Lauren Galvan is based on her entire undergraduate concentration, which she developed as an "independent concentration" on her interests in wellness and mental health. The second is submitted by the Student Health Council, which is a modeled on and works with the Physicians Health Council of the RI Department of Medical Licensure, and offers many opportunities to address wellness as our students progress as physicians. Their paper outlines their role and goals.

THE STOCK MARKET OF MENTAL HEALTH

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Think about your mental health for a minute.

What are you feeling right now?

Now, think about the history of your mental health.

How were you feeling yesterday? Five months ago? Five years ago?

My answers look like this: Sleepy, fine, the worst I've ever felt, fine. Many of us will have varying answers to these questions that, if were plotted on a graph, may look like a sinusoidal wave, or, if we're into chemistry, a conformational energy diagram.

But guess what?

That's completely normal.

You see, our mental health is much like the stock market. It goes up and down. It fluctuates every second of every day. Sometimes we're sick – we might be experiencing a depressive episode. Or, if we have anxiety, we might be having an anxiety attack. But then, at other times, we're healthy and happy – our significant other might have proposed, or, if we don't believe in marriage, we might have gotten ourselves a new job...or a new puppy.

And just like we invest in the stock market, we invest in our own mental health...or at least we think we do. Wouldn't it sound great on a resume to call yourself a self-employed Mental Health Investor? Maybe not.

The problem is that the job description of being a Mental Health Investor is not what it sounds like. On the surface, it sounds like we should invest in our mental health and pay some good money to buy medication when we detect a problem. And while that is true to an extent, the more important and most difficult bullet point on the job description is to pay close attention to what is going on with our emotions and remain a balanced observer while doing it.

This is one exception to the stock market metaphor, and many of us do not realize it until it is too late – until we're sitting in the bathroom stall crying about our unfulfilling job, or tumultuous relationship, or, God forbid, our unsuccessful life. Some of us do not realize the importance of remaining a balanced observer until we're diagnosed with a label that holds an enormously negative and persistent social stigma.

When our mind goes "public," when we experience some emotional state, our mind gives us the opportunity to purchase a part of the company. In other words, it gives us the chance to "buy-into" our emotion. Naturally, human beings like to invest energy in our more extreme emotions because of the side effect of intense pleasure. Or because, in the case of intense pain, our evolutionary instincts draw us to pay attention to that end of the spectrum to possibly prevent harm. However, the more we invest in those states, the more the stock – and stake – increases. The stock increases when we invest in pleasurable experiences and it also increases when we experience pain and invest in trying to avoid it. This leaves us with irrefutable high stake emotional states that make us more at risk for mental health challenges.

Sometimes, we even become so engrossed in the investment of pleasure or in the investment of avoiding pain that we learn to live with those states and feel comfortable in them, which can be seriously dangerous to our holistic health and well-being and set us up for major disappointments. These

states leave us with the Freudian “pleasure principle” goal of achieving the perfect life without hardship, making our focus stray from our own life’s reality. Instead of focusing on what *is*, our focus during these states tends to gravitate to what *should be* or what *was*. When the stock and stake increases like this, we subconsciously garner more expectations about the perfect “happy” lives we should be living, but for some reason that we always manage to find, aren’t. We throw our emotional health out of balance without even knowing we’re doing it. And that is the most dangerous thing of all.

The more we invest our energy into those extreme states of mind, the less energy we have to expend on what I call the “in-between” experiences of life, like the ordinary yet majestic butterfly fluttering above your hair, or your baby son’s small yet gorgeous giggle, or the peace that comes simply by sitting still in a chair after a long day at work. By solely investing in the high-risk emotions that we already know so well and have been invested in for so long – those of seeking pleasure and those of avoiding pain – we lose touch with what is happening “in the now” – in the present moment – which many of us are unfamiliar with and should get to know, because the present is a pretty cool place to be.

We have the power to choose where we put our energy and

where we focus our attention. But by no longer investing so much energy into those high-risk stocks, we can scratch “Mental Health Investor” off of our resume and call ourselves “mental health observers” instead. Let us remain balanced while simply observing our fluctuating emotional states of life, and if our mind wants us to pay attention to something, by all means, let’s pay attention to it. But always remember to stay balanced. There are an infinite number of things in the present moment that we can experience.

The distance we can put between ourselves and our thoughts, emotions, and feelings by observing them instead of investing so much in them may come in handy when making decisions, not to mention it will give us ample space for reflection and pave the way for self-acceptance.

I think that once we realize one alternative way to invest in our mental health is to simply observe our emotions and be mindful of them, we will all find a little bit of inner peace in the chaotic stock market that is our external – and internal – world.

So like my mentors have said to me countless times before, and as I say to you for the first time but certainly not the last:

Go, and experience.

A Student Collaboration to Address Mental Health Wellness in Medical School

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CHRISTINE MONTROSS, MD, MFA

We know that medical students have high rates of depression, are more likely to commit suicide and are at higher risk of substance abuse.^{1,2} At the Student Health Council (SHC) of Alpert Medical School, we seek to address these statistics and promote well-being. Our first step is to normalize the impact that medical school can have on one's mental health.

A few times a year, we hand out blank postcards to all medical students and collect their anonymous "secrets" via a locked mailbox to display at "Our Med School Confession" events. One particular sentiment — isolation from others — is repeatedly expressed in the over 80 secrets we have gathered thus far. Students articulate that despite being surrounded by caring people, they often feel alone.

Medical school is indeed full of caring people — those who give up sleep, sacrifice connections with friends, and neglect their own bodily needs while running around on the wards — all in order to care for patients. But how successful are we at caring for each other? We are told to be heroes, and heroes show no signs of weakness. We are taught not to have needs, or at the very least to dismiss them as unimportant. So if we deny ourselves our own needs, perhaps we also fail to recognize and support those of our peers, and the result is a group of people in which many members feel lonely.

Struggling with a sense of isolation is difficult enough, and the demands of medical school only exacerbate these feelings. In our first two preclinical years, we must master enormous amounts of information without much context. A monthly cycle of exams descends upon us, and our evaluations and grades depend on little else but our ability to memorize material and tackle complicated test questions. For most of us, it is the first time we are no longer at the top of our classes, the first time we confront failure, the first time we lose sight of our passions and interests outside of medicine.

In the latter two years, we are whisked away rather unceremoniously to the hospitals, where we occupy the very lowest position in medicine's hierarchy. Our short white coats mark us as experts to patients but as clumsy learners to our residents and attendings, who expect us to know things we have never learned, and to understand how to function in the established culture of each hospital. As we begin to navigate these unfamiliar spaces, we are confronted with diseases, procedures, blood, tissue and sometimes death. Yet the perfect medical student remains unaffected by the long hours, the sometimes disparaging comments of our superiors, and the heart-rending stories of our patients. Rather,

we are expected to exhibit enthusiastic smiles and project an unadulterated eagerness. The daily exhaustion and self-doubt is enough to cause depression or anxiety for those who have never experienced them, as well as to exacerbate any mental health problems a student may already endure.

In its conception, the SHC followed the model of the Physician Health Committee, a Rhode Island Medical Society group that offers confidential assistance to doctors affected by substance abuse or psychiatric issues, with the goal of preventing negative impacts on patient care and on the physician's licensing status and career. Building upon this model, we have since grown, and now have various components to our programs. One major goal of the SHC is to provide confidential peer counseling services. So much of what keeps medical students from seeking help is stigma — the fear that others might find out that we are not strong enough to survive medical school without help. The SHC works both with undergraduate students in the Program in Liberal Medical Education (PLME) and our fellow medical students by offering support, referring students to counseling resources, and most importantly lending the ear of someone who knows what the experience of medical school is like. By advertising ourselves as peers who are willing to listen to fellow students' struggles, we hope to disempower the stigma associated with isolation and vulnerability.

Throughout the year, we create safe spaces to foster discussion about the various issues faced by physicians-in-training. We hold a Depression Panel annually, an event closed to administrators and faculty, in which a number of third- and fourth-year medical students who have struggled with depression speak openly about their experiences. For the yearly Physicians in Recovery talk, the SHC hosts a physician speaker who has a personal history with substance abuse. We have also hosted community support groups in the aftermath of events such as the death of a fellow student, the Boston marathon bombing and the no indictment verdicts of Eric Garner and Michael Brown.

In addition, we work with our administration and course leaders to advocate for student wellness in our community. We have partnered with the Doctoring program to hold students-only drop-in sessions on days that address difficult topics, such as depression and interpersonal violence. We talk to first year students during their orientation, lead empathy and wellness workshops for doctoring students, and address rising third years about issues of mistreatment and self-care

before they enter the hospital.

We also recognize that high-achieving underrepresented minorities may face additional challenges, often in the form of alienating commonplace exchanges or in confronting stereotyped based expectations.^{3,4} We are working to improve collaboration with the Office of Diversity and Multicultural Affairs to foster open discussion and activism regarding minority mental health in both medical school and in our future practice as clinicians.

Our model is piecemeal and experimental, and continues to change as new members from each successive class bring their diverse life experiences, perspectives, and goals. While the SHC may not be able to change the culture of medicine, we normalize its effects by acknowledging its existence. We believe that our presence tells our community it is okay to grieve in medical school, okay to be affected by our surroundings and okay to take the time to care for ourselves and each other.

Acknowledgment

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