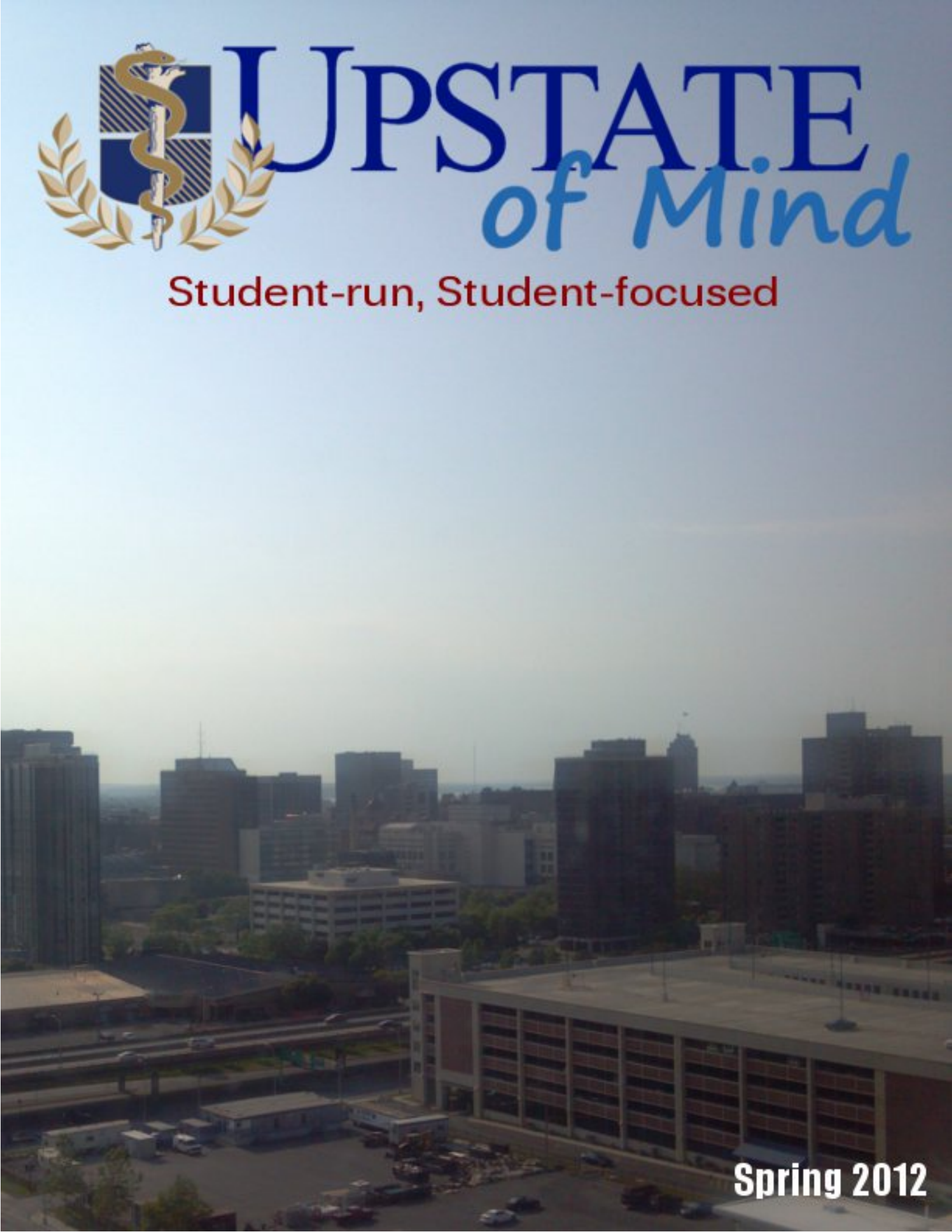
Upstate of Mind

Student-run, Student-focused



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Our Motto is STUDENTS first!

Bedside Manners

By Dr. Zeah Venitelli

It was my very first day on the Labor and Delivery floor at Crouse Hospital, and I was very anxious and excited about starting my OB/GYN rotation. Even though this was one of my last rotations of the third year of medical school, I had the feeling that nothing could quite prepare me for what I was likely to experience that day.

I had no idea how true those thoughts would be within one hour of being on the floor. As I was preparing to help with a Cesarean section that morning, the senior resident called me over. She said, “We will need to post-pone the first scheduled case. We have a mother with triplets coming here emergently and we need to do a Cesarean section.”

Her words gave me goose bumps. I looked at her stunned for moment, and for a very good reason. I am one of triplets, and my brother, sister, and I were born at Crouse Hospital in Syracuse then twenty-seven years ago.

In my excitement, I blurted out this information to my resident. Unbeknownst to me, the attending obstetrician was standing behind me and heard my whole story. When I finally noticed her behind me, I whirled around, and before I could even utter the words to ask permission to watch the delivery, she told me, “Zeah you will scrub in. Get your gown, gloves, and boots and get ready.”

It seemed like only minutes later that I was scrubbing my hands as I watched the anxious mother and father as they were both ushered into the room. Before I knew it, I was gowned, gloved, and standing beside the obstetrician and chief resident, ready to begin.

What happened in the next several moments can only be described as incredible speed, skill, and concentration on the parts of the obstetrician and chief resident. Minutes later, three absolutely beautiful babies were delivered. All three of them gave those sweet, incredible little cries of new life. Tears welled up in my eyes as I saw each one handed off to the waiting nurses and physicians.

After the delivery, the obstetrician turned to speak to the mother and father. I remember looking up at the father, who stood behind the sterile drape holding his wife’s hand, and he had tears in his eyes. The obstetrician said to them, “Did you know that a triplet just helped deliver your triplets?” And I started to cry, tears of pure happiness streaming down into my surgical mask.

I am still searching for the right words to describe how it felt at that exact moment standing next to the obstetrician on the sterile-side of the drape, and being a part of that delivery. The best I can currently do is to say that it is one of the greatest moments of my life.

It appears that in a very unique way, I have indeed “come full circle.” My life started here in Syracuse now twenty-eight years ago, and I couldn’t have imagined in my wildest dreams the adventures that would bring me back to Syracuse or that were waiting for me through all four years of school here at SUNY Upstate. The moment I’ve described is only one of several remarkable and profound

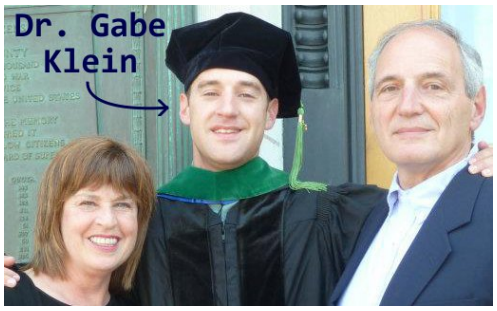
experiences that happened during my studies here.

If I had not come to SUNY Upstate I also wouldn't have met my incredible classmates, who after all my travels are still some of the greatest people I have ever encountered. I am incredibly fortunate to have them as my future colleagues. I also wouldn't have met my teachers and mentors, who showed me what a privilege it is to study and practice medicine.

Most importantly, I wouldn't have the opportunity to bring three new little lives into being in the exact same place where mine began. To me, it is the greatest gift of all.

And if I had to do the whole thing over again, I would without hesitation do it all over again in exactly the same way.

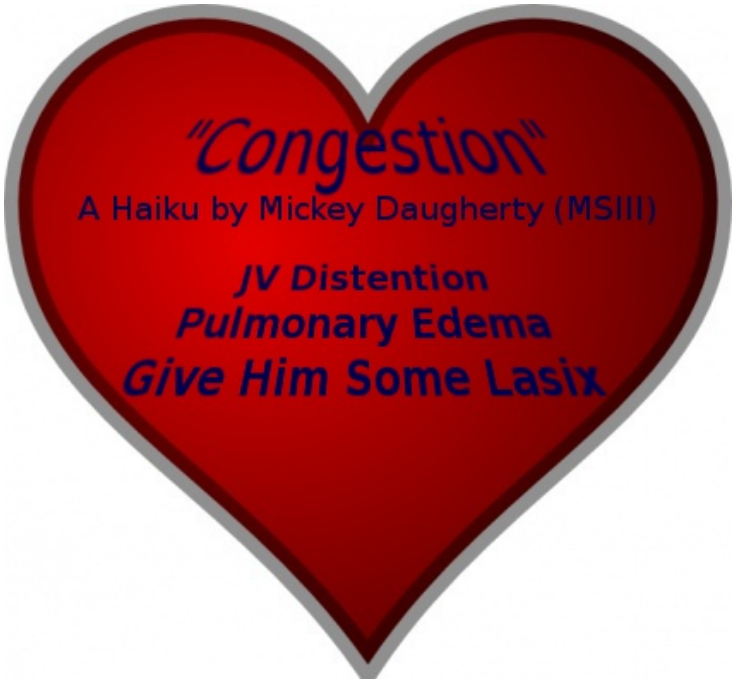
Editor's Note: Zeah will be training in general surgery at St. Luke's-Roosevelt.



I was at an interview (here actually) with a transplant surgeon and she was on call. She got a phone call in the middle of the interview and was told, "We have a 67 year old male, hep c core positive, creatinine was 1.9 yesterday, 3.6 today." She told the person on the phone to wait, turns to me and asks, "Gabe, do I take this kidney?" I said no, and she proceeded to pick up the phone and say, "Thanks Tom, but we'll pass, have a good one," and hung up.

Editor's Note: Gabe will be training in general surgery at Stony Brook

They told us at the beginning of this year that we should rank every program we interviewed at. I fully intended on doing that, until I went to my third interview. I applied to this program because it was close to where my family is, and a few of my cousins had delivered their babies at their OB hospital. They adored the care they received there, and refused to go anywhere else. Couldn't hurt to apply, right? I should have realized when they didn't offer an applicant dinner the night before that I should have canceled the interview. The day started at 8:00 AM. Right away, I could tell something was off about this place. To start, there was no itinerary. I had no idea how many interviews I had, who I would be meeting with, or when my day would be over. I've always been a clock-watcher, and to me that is pure hell. They put the four of us applicants in a large room, presumably where their resident



lectures were held, to start the day with a Powerpoint presentation by the residency director. While he was starting his talk, a woman sat down in the back corner with a stack of thick charts and a laptop and plugged in a portable scanner – the kind that you unfold; one that makes my HP printer/scanner/copier I bought my freshman year of college for $100 appear heavy duty. She then proceeded to take the charts apart page by page and scan them into the computer. This is about five feet away from where the director is giving us his spiel. By 8:15, I knew I wanted to go home. I texted my mom to tell her and she responds, “When can you leave?” Only God knows.

My first interview of the day is with the residency director. I walk in the door, shake his hand, introduce myself, and his first question is, “So you’re an MD grad from an American med school… why are you here?” Not what I was expecting. Apparently they don’t get my type around there. It seemed that opening dictated the rest of the interview, with him trying to convince me why the other program in the area would be a better fit for someone with my ‘credentials’. One of the other applicants had asked one of the residents earlier in the other room how many interns they would be taking next year, and she had told her it varied. I asked the director about this, and he goes to me, “Why do you care? Obviously you would get a spot.” Thank you, I didn’t feel out of place here already. It turns out the answer to that question varies, because they get different funding each year, sometimes able to afford more interns than other years. He also at this point interjected how the hospital had been bankrupt but was slowly crawling out of the hole. That explains the lack of dinner, I guess.

After my first interview, the next chunk of time was spent with the residents, where they proceeded to ask awkward questions to ‘get to know’ us. The third year resident told us she does not feel prepared to be an attending. Oy. The first question was, “Tell me about a situation, could be positive, could be negative, that shaped your life.” We went around the room answering this. Now, this was only my third interview, but usually in this situation, the question is, “What do you do for fun? Do you have any siblings?” etc, etc. I look around the room and all of the other applicants have the same puzzled looks on their faces. After we all painfully answer such a vague question, the resident now poses this question: “Tell me what you would do if you are on a team and you and your senior disagree with how to treat your patient.” I couldn’t handle it. This is family medicine, the grassroots stage of evidence based medicine. There shouldn’t be any disagreement; there should be literature. Besides, all of these decisions ultimately rest on the attending. Thankfully, just as it was about to be my turn, they called me to go on a tour of the precepting room.

There, I meet another attending who told me he knew what I was going through, as his daughter had just gone through this same process last year. I hesitantly asked him, “Oh is she here?” He replied with, “Of course not! She’s at Brown.” Knowing I have an interview there coming up in a few weeks, I decide it’s probably the best use of my time if I ask him what his daughter likes best about her program. While I’m talking to him, in comes an intern who looks about as thrilled as I am to be there. Finally hey call me back to the other room for my last interview.

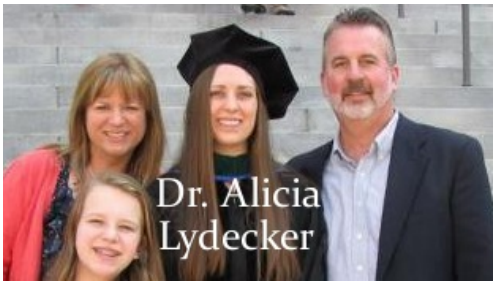
After the interview, the residents took us all to lunch. Well, actually, first they asked if any of the applicants could drive to lunch. This place was continually blowing my mind. At my last interview the program coordinator rented a minivan for the day just to drive around the applicants and to take us for coffee at the end of the day. Not the case here. They finally sorted out the transportation issue and we made it to lunch around 1:00, much later than it was apparently expected on the imaginary itinerary. I was so scared and convinced they were going to tell us we were paying for our own lunches that all I ordered was the sandwich and soup special of the day. After lunch, as the residents asked the other applicants what time they needed to make it to the airport or bus station, they remarked we would probably be cutting it close o the tour. They then proceeded to order and eat desserts.

We started the tour of hospital #1 sometime after 2:00. I learned that the woman who had been in the room earlier in the day was scanning in charts for a possible EMR sometime in the future. As of now, there was nothing in place. If you admitted a patient through the ED, there was no dictation summary of their last visit anywhere. You needed to call

medical records up and have them send you a physical copy of the chart. After this, we went to hospital #2, which is where they do their OB. The two residents giving us the tour had split up driving from the other hospital. I was in the second car, fearing for my life as the resident was on the phone yelling in Spanish at someone on the other end, not using any sort of earpiece, and certainly not paying attention. As much as I wanted the day to end, I did not want it to end by getting in a car accident with this woman. When we finally get to the other hospital, she pulls into one of the parking lots and has us wait outside until her colleague arrives, saying that she'll lose all cell service once she goes inside and we will never find the other girl. It is a freezing cold day in November, mind you. Another applicant and I ask if she will just let us in and direct us to the bathroom. "No," she says, "They are almost here." I ask her if it's possible the other girl could have parked on the other side and went in the other door. "No," she says, "We always park here." "Okay, but they left before us and we hit every red light on the way here." "No, no, she will be here. We park here." After about five minutes of this, her phone rings and it's the other resident asking, "Where are you guys? We've been inside waiting for ten minutes." She turns to us, "Oh you ht! They did go in the other door!" Told you.

Finally, the day ends and one of the other applicants says she will be calling for a cab to get to the airport. At this point, both of the residents start with, "No, no! We will bring you! Save your money!" They then start debating as to who can actually bring her, as one is meeting with a patient at 3:30 and the other needs to go pick up her kids. The girl keeps interjecting that she can just call a cab, which launches them into repeating the same things over and over again. I look down at my watch, realize what time it is, and offer to bring her to the airport on my way home, out of fear she'll miss her flight while they debate in the parking lot. We hopped in my car and got the heck out of there.

Editor's Note: Toni will be training in family medicine at New Hanover Regional Medical Center



I have an interview story for ya. I was at an interview and they had a bowl of ghiradelli chocolate squares out. I was starving and didn't want my stomach to growl louder than my next interviewer, so I grabbed one with a mint filling. I took a bite and a piece broke off and fell on the floor. Now, this was a gooey mint filling and the floor was one that residents have their lectures in (in scrubs and hospital shoes mind you). I go to pick it up and throw it away and a fellow applicant goes, "I'll eat it!" I thought he was kidding because the thing was full of lint, but he insists he's serious. He says it 'strengthens the immune system' and actually ate it. Yuck.

Editor's Note: Alicia will be training in emergency medicine at UMASS

Title[i] (with edits)

Sam asked me to write an article because he was intrigued by some nonsense I had previously written. Unfortunately (or perhaps fortunately), the writing was far too vulgar and was rejected by our superiors. Therefore, I will conform to the "professional" expectations and write about my wonderful experience in Haiti. I swear I'm not being facetious. I think. No I'm not. Maybe.

I've found my life to be defined by certain emotions. My medical school experience up to Haiti had mainly been composed of fleeting romanticism, anger, and the occasional instance of achievement (occasional may be too generous) and mostly confusion.

The romanticism influenced my decision to become a physician. For example, when I thought about entering medical school, I had ambitious hopes of what kind of doctor I wanted to be. The ambitious hopes were rooted in one motivating factor – the innate human need for social connection. In my mind, the most ideal form of social connection can be achieved through altruistic means. In fewer words, I wanted to help people. Through doctoring, I believed I could reach this ideal. I wanted the patient to go through a certain thought process.

[redacted][iii]

The thought process idealized the physician-patient relationship: A patient and doctor as members of a team accomplishing a goal together. That goal is in the best interests of the patient's emotional and physical well-being. To spend life in the service of others while feeling connected with these people; perhaps that was a silly reason to go into medicine. My assumption was that I'd look back on my life at age 85 and feel like I made a difference.[iv]

[redacted][v]

I eventually realized that ideals are never met. There is no such thing. The limited clinical experience during the first two years, the realization that external factors influence medicine[vi], the sacrificing of my youth, and the whole probation thing made me lose sight of why I was doing any of this. So the eventual result was cynicism, anger, one and a half pack per day smoking habit[vii] and other bad things.

Unfortunately for me, not taking responsibility for the anger, fear, and cynicism made me a selfish, arrogant [redacted][viii]. Once jaded, I found new motivations. For some, these motivations may have been money, women, and power. And these motivations aren't compatible with the humanistic ideals of medicine.

[redacted]

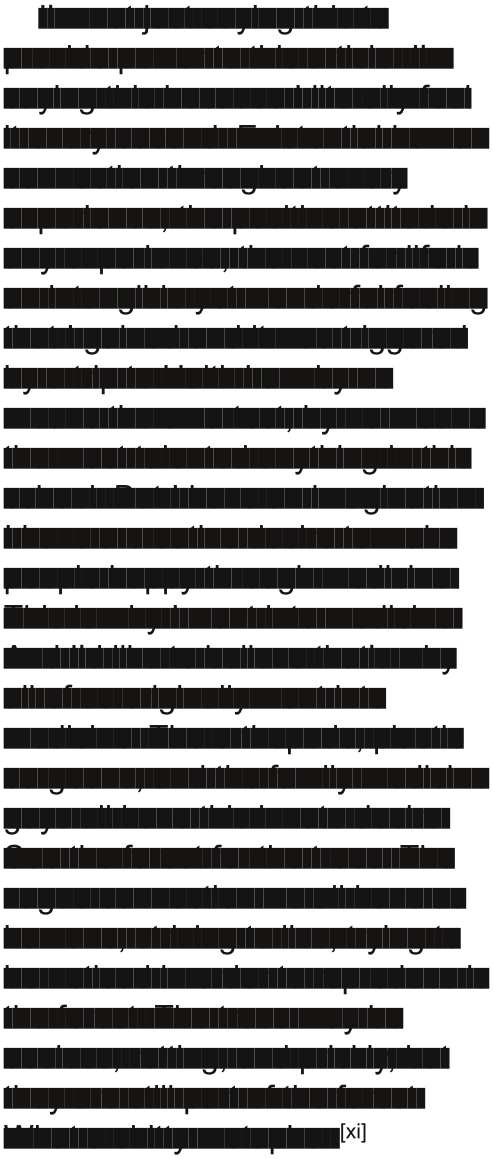
[redacted][ix]

Luckily, I had some foresight and recognition of the person I was becoming. I decided no thanks. But to get to that point, I needed to travel.

And this is why Haiti was wonderful. I can tell you about the nice things we did for people, but I don't think any of you care. It was simply me craving some experience, some perspective, some taste of reality that would affect me, that would move me, that would ignite me into a flame of optimistic, romantic mania. That is exactly what I got.

We lived simply. We spent time away from the numbing distractions of everyday life. There was time to think. I realized that the constant bombardment of pseudo-problems were only as large as I made them. This Haitian kid is dying; he has no chance to experience love, no chance to experience everlasting friendship, no chance to eat a rare steak, no chance to ponder the stars and the universe, and no chance to experience the awesomeness of living. The emotion evoked from seeing a child suffer is one of the most powerful things I've ever experienced; though not suddenly, I found a role for myself as a physician. I found meaning in living.

I met many interesting people. But there was this one man in particular. Throughout the day he was catching conch for us on the beach. He was cooking food for us. We shared a drink amongst other treats. But there was something about him. He had these rust colored eyes that simultaneously expressed pain and hope. He said to us,
"I want you to like me; I want you to believe in me, I want you to believe in Haiti."
This was during sunset, on a beautiful beach. I wanted to seriously hug this sweet, wonderful man.[x] And I'm not romanticizing the interaction. It was real human connection.



[redacted][xi]

From this experience, I felt the compassion for a stranger. I had no superficial similarities with these people. My life experience has been in stark contrast to the experience of a Haitian man growing up in uncertainty and poverty. I reached a few conclusions based on the overall experience. Those conclusions have made me realize that medical school education is what I make of it. Whatever I want. It's been better since. I think?
And I still have no idea of whether I was being facetious or not. Anything I say can be taken with a grain of salt.

[i] Sorry. I couldn't think of a title that was less obnoxious. If I could think of a phrase that represents this writing, I would appear dimwitted in some way. Catch 22, I think? If not, I meant it as a Michael Scott reference.

[ii] Originally, I had wanted to remain anonymous and call myself Lieutenant Columbo. I decided to stop being an ass.

[iii] This was stupid. I was trying to be funny. I wasn't

[iv] At 21 years old, I also assumed I'd die with a hot 65 year old wife, beautiful children and loving butlers (who took care of my bat mobile and spaceship)

[v] Aaron Stupple just sent that email about Wegmans. I thought it was pretty hilarious.

[vi] Consumerism, Managerialism, Capitalism, voodoo

[vii] I have since then quit, except when I drink socially. And cigars, cigars are alright. Right? Shut up. It's a long process

[viii] Rhymes with stick

[ix] So around here I became a bit preachy. I concluded that consciousness is a product of evolution, in that ideals, culture, and language transmit behaviors that increase survival. I supported the idea that we can be innately good and moral creatures through mere consciousness. And as a result of adopting ideals, culture, and language that are virtuous and moral we can save the world as doctors.

I then spoke to Bradley Klein and he referred me to a book titled the "illusion of conscious will", by Daniel Wegener. Then I read "Letters from the Underground," by Fyodor Dostoyevsky. I suggest reading the latter, the former is probably good too but Bradley paraphrased it for me well enough. The perspective I gained from those works led me to think that it's silly to want everyone to agree with me. Besides, some people don't believe in evolution (I myself don't believe in the number 2).

The reason for taking that paragraph out is because I realized that what works for one person will not always work for another. It's easy to make judgments and demands from people I don't know. So I realized I haven't lived enough life and I'm not awesome enough yet to tell people what they should do or not do in medical school. I didn't want to change anyone's mind and didn't want to appear self-important. Although I'm told I am.

[x] I swore in this sentence. Sam said I should take it out because me cursing doesn't add anything to the statement. I agreed.

[xi] More crap

THE FOLLOWING SECTION HAS BEEN RATED

PG Post-Graduate Perspectives

BY UPSTATE OF MIND STAFF

The Inside Scoop on Emergency Medicine

This is an interview of Josh Nelson, PGY1 in emergency medicine here at Upstate. Josh is a graduate of our college of medicine. The questions were asked by Rachelle Antos, MS3. The two were recently engaged!

Rachelle: Why emergency medicine?

Josh: Because it's cool. You're the ultimate diagnosticians. You see patients at first presentation and have to figure out what is wrong with them. At times, you have very little information to work with in order to diagnose and treat the patient. It's what I imagined medicine was before I had any practical experience. I imagined that people would come to me with problems that no one had tried to solve before and that I would get the chance to solve them. There are puzzles, and I love puzzles.

R: What makes the specialty awesome?

J: The above, plus it is extremely varied/predictable/procedural/fast/exciting. It is very predictable in that you know when you are going home. However, it is complicated and unpredictable in other ways. As far as I can tell, the lifestyle is pretty good. I say 'as far as I can tell' because I'm an intern, not a rich attending. As an intern at upstate, we work 20 eight-hour shifts a month. In general, academic attendings work about 12 and those working in the community (non-academic) settings work 16.

We perform a ton of procedures routinely (Lumbar punctures/Endotracheal intubation/Central Venous Cannulation/Splinting/Fracture Reduction/Moderate Sedation/Suturing/Chest Tube placement/Abscess incision and drainage/ultrasonography et cetera). I've always enjoyed working with my hands as well as my brain. In this specialty, you do both at a rapid pace.

R: What makes the specialty suck a little?

J: The varying hours are a little hard to get used to but you quickly adapt. A good percentage of the time, I can't have dinner with my family. We work weekends, holidays and overnights. While we get a good amount of time off, we may not be home when it is optimal.

We have to know a little bit about every specialty, which is daunting. Our scope of knowledge is very broad. Each field is so expansive that you come to know a little about everything. Because of this, especially at an academic institution, we naturally consult subspecialists. From their perspectives, we may look like we don't know as much as we should. It's strange to think that your colleagues who have been through the same amount of education, training and experience as you could think you're so incompetent simply because of the specialty you are in. I see how this point of view can develop, as silly as it may be. This way of thinking is pervasive but at least it's going in the right direction; away.

R: What makes a good Program?

J: Usually the structure of the program is what's discussed and praised as being the most important factor. It is definitely important, but not the only or most relevant thing to consider. If your fellow residents and the faculty within your program are not people you can get along with, then you will have a terrible time during residency. This includes your program director, other faculty, your fellow residents, secretaries, nurses and the list goes on. This gets down played when people talk about residency, but I think it is very important. On

many occasions, I've heard about how important it is to get a sense if the residents are happy, but usually that's where that thread of advice ends. The conversation quickly progresses to other topics.

I'm sure you already know this because it's intuitive but a good program is flexible; it can change for you or with you as you progress. You want faculty members who, in response to your crazy ideas, say "Lets see how we can make that work," instead of, "Are you stupid? Forget about that idea." You want them to be laid back. The last thing you want is a high-strung attending or adviser.

The residents are a huge source of information about a program. They can tell you about the detail as well as give you a sense of how much you can rely on them. Your fellow residents are key because, even if you don't socialize with them, you need them to be accommodating. You will need each other to switch shifts, to validate how much you don't know, to discuss fellowship thoughts, to discuss off service rotations and to teach each other how not to look like idiots.

The best way to tell if the program is awesome is to see if they speak candidly with you about things. Be leery of the "lines" that they feed you: "Oh we all get along and go out together", "We are like a family, really". Really? No. Ask them specific questions; the truth is in the details. Where and when did they hang out last? Who is the black sheep among the residents? If they answer these questions without flinching then continue to fire away.

R: What would you change about your program if you could?

J: The program itself could not be any better and I mean that from the bottom of my heart. No really, I think this is best place I've interviewed. I'm biased because I'm marrying the medical student interviewing me at the moment. There was no other place that I wanted to be, due to her location, and was amazingly lucky to have landed an awesome program.

Shameless plugging aside, I do have problems in general with the training in emergency medicine. These problems exist everywhere and are not limited to one institution. The volume of patients presenting to the ER is large and increasing. All of these patients need to be seen, so there is a push in the EM to see as many patients as you possibly can. This problem is not limited to Emergency Medicine either. When you are an attending and in a community setting, you will be expected to see a high volume of patients and you won't survive if you can't, so it is absolutely necessary that programs prepare you for this inevitability. However, this idea of "move the meat" trickles down into the early years of training, whether it's intentional or not, and I believe it's completely inappropriate. Many of my attendings feel similar but the problem persists. With the majority of new residents, it is often self-imposed.

As interns and residents, we need additional time to really think and learn about the patients and their complaints. I want to start a "stop and smell the meat" campaign. It doesn't mean you must sacrifice efficiency – if this is the 100th patient with chest pain you've seen, move the meat. But if it is the first, take a whiff.

R: What is the hardest part about being a resident in the ER?

J: That's easy – the scope of the practice of Emergency Medicine is enormous. It is very difficult to become comfortable dealing with problems you see rarely. There are common things that are dealt with on every shift and those become routine. There are problems that fall within the prevue of emergency medicine but are seen only once a year or even once in a career. Trying to stay on top of this list is very intimidating.

R: What is one thing you would change about your specialty?

J: I would change the culture in EM with respect to the amount of risk they are willing to take. High-risk complaints are seen frequently and are often met with a low threshold to admit to the hospital. This may often be a medically defensible position. But often times the discussions that happen among ER physicians are not related to the risk to the patient but to the risk to the

physician. The conversations usually circle around the probability of missing a diagnosis and subsequently being sued. There seems to me to be no consensus on the level of risk that is acceptable in the population for a particular diagnosis. Each practitioner seems to define his or her own threshold and operate from there. Some seem to have a wildly fluctuating threshold that appears chaotic. I don't claim to have a solution. Perhaps defining a threshold would interfere with the ability of doctors to make clinical decisions. It's simply a point of frustration for me. I interact with attendings that vary widely on this topic and trying to adapt can be a little annoying.

R: They say that certain personality types flock to certain specialties. What would you say to that?

J: Its bullshit. I would like to think that people go into certain specialties because they are interested in them. This is not true in a lot of cases of course. Why else would those with higher board scores and class ranks go into the more competitive specialties? They are obviously being driven by other factors. I am an optimist and think that the majority find something that interests them and choose that field. Now, simply because your interests and motivations align you to a specialty, does that mean that all people that share your specialty alignment share your personality type? Consider one person who chooses thoracic surgery for the income and another who chooses it for the prestige. They have both decided on the same specialty, but does that mean they behave similarly? Of course not. You are in medical school and you study a lot… does that mean you are similar to the medical student next to you? Are you that type A personality you have heard about since you arrived? Maybe you are or maybe you aren't. It's much more likely that people are put in similar situations and conform. I think the same thing happens when you pick a specialty. No one would make the argument that people who drive erratically and do so quickly become taxi drivers

R: Do you think most EM doctors would choose their specialty if they had to do it all over again?

J: There are studies out there that address this question. The number I remember hovers somewhere around 50% of those who would or wouldn't choose the same specialty. The grass is always greener…

R: For students interested in EM, what resources would you suggest for them to learn more about the specialty?

J: I used student doctor network, but for some reason that site is full of liars and assholes. I would point students towards podcasts and blogs (EMCRIT.ORG, ERCAST.ORG, EMRA website, society for academic emergency medicine) just to name a few.

R: Are there EM fellowships? Are you going into a fellowship?

J: There are several fellowships but not all are accredited so be careful. I am going to do a critical care fellowship and, so the majority of my knowledge is in that area. For details, I would go to the SAEM or EMRA websites. That being said, here are the fellowships I can remember: Critical care, Pediatrics, Toxicology, Hyperbarics (wound care), EMS, Ultrasound, and Wilderness medicine. For those interested there are also combined programs: EM/IM, EM/IM/Critical care, EM/FAMILY, EM/PEDS. There are probably more combined programs but those are the only ones I can remember.

'Healing toes!!??'– How my attending taught me much more than just the 'science' of medicine!

By Pallawi Torka, PGY2, Internal Medicine

I was warned about her. 'She is always in pain, keeps on asking for more narcotics,' my colleague said while signing out to me. And true to the description, she lashed out at me that first time. Mrs. Unfortunate (Mrs. U, for short), a 37-year-old white female, was shot by her PTSD-plagued husband in the neck 6 months back before he shot himself. She is quadriparetic now, forever doomed to the confines of her bed. He is in jail, in one piece. 'Of course she has a bad attitude', I thought, 'She is probably mad at the whole world!'

The first few days were not pleasant. Mrs. U had a deep sacral decubitus ulcer extending down to the bone which could be clearly seen. There was nothing much to do medically for her. The

ulcer was being taken care of by the wound care team. Physical and occupational therapists came in religiously every day to make her exercise, fighting the losing battle to keep her joints from getting stiff and bent permanently. What did I do for her? Well, she had developed sacral osteomyelitis and needed intravenous antibiotics. I entered the order for antibiotics in the computer. She had labs drawn twice weekly to monitor her renal function. That was my responsibility to monitor. I really didn't need to see her in person to fulfill these responsibilities. I needed a computer to read the wound care notes, check labs and enter orders. As a busy intern, juggling ten patients at a time, she was probably the lowest on my priority list. On most days, I didn't even get to see her before rounds, not that I really wanted to. I knew that all she would do is complain, no matter what we did for her. Increasing the pain meds did not make any difference. She would just ask for more every couple of days. Nothing satisfied her. Truth be told, every doctor has at least one patient that he/she dreads to see; Mrs. U was mine.

So, I did the easiest thing possible – I ignored her, just like the other residents before me. She did not need much in terms of medical management. As weeks passed, the attendings on service changed, the residents changed, and the other patients changed, but Mrs. U remained the one constant part of the team.

One fine day, about a week into my rotation, the nurse paged me – 'Doctor, Mrs. U needs her toenails cut'.

'Ok sure, so cut them,' I said.

'No doctor, nurses are not allowed to cut nails, and we don't have inpatient podiatry in the hospital,' came the reply.

'You've got to be kidding me,' I said. 'Why aren't you allowed to cut her nails?'

'Don't know doctor, just rules are rules.'

I pleaded with her – 'Make an exception, just this time.' She wouldn't listen.

I tried to be authoritative – 'Let me talk to the nurse-in-charge.' That didn't help, she had the same answer.

I talked to my resident. He looked as affronted as I felt. 'No way! We are here to learn how to treat myocardial infarctions, strokes, pneumonia, save lives, not do menial jobs like cutting someone's toenails! We don't have time for this!' he said. 'Let's report this to the attending.'

So we marched over to the attending, Dr. B, looking for sympathy. 'How can they ask us to cut toenails Dr. B.? Maybe you can convince the nurses to do it!' To our dismay, she smiled and said 'Well, that's not a big deal. You can do it.'

'Humph.' So there I was, stuck with the lowly job of clipping toenails. Ok, part of the training. So, I went over to the patient's side. 'Hi Mrs. U, are you all set to get your toenails trimmed?' I chirped. 'Sure doc, but they don't have any clippers on this floor. Can you buy me a clipper from the gift shop, or maybe you can pick one up for me the next time you go grocery shopping! Oh and also pick up a nail file and then we will see.' I moved away deflated. 'Also doc, can you give me something for this back pain, its killing me.' 'Yeah, sure Mrs. U.'

Again, back to the nurses' station. 'Hi! Can I get a nail clipper?' 'Sorry doc, we don't stock that. Maybe if you put in a special request, I can get it from central supply. Or maybe we can borrow one from the rehab center. You see, patients don't stay that long enough on our floor, that they need their nails trimmed.' What do I do now? What have I gotten myself into?

My attending shows up. She listens to my saga and senses my reluctance. 'I have never cut another person's nails before Dr. B, what if I overcut and they bleed?'

She smiles again – 'You know what, don't worry about it. You have lots on your plate. Go on, I will handle this.' I profusely thank her and scurry away as fast as I can, thankful to get out of this chore.

The next day, I had forgotten all about the toenails. As usual I don't see Mrs. U before rounds. She is the last patient we see on rounds. As soon as we enter the room, her face lights up! 'My docs are here,' she says 'Good to see you guys!' We are stunned! 'Wait a minute! What happened to her?'

Dr. B takes the lead. 'How are you Mrs. U? Ready to get your nails painted?' She brings out a pretty pink colored nail polish. 'Oh yeah!' says our overjoyed patient. 'Ok I will come in the afternoon and do them for you. Oh and how's the pain doing?' 'It's holding up doc. I think the medicines are finally working.'

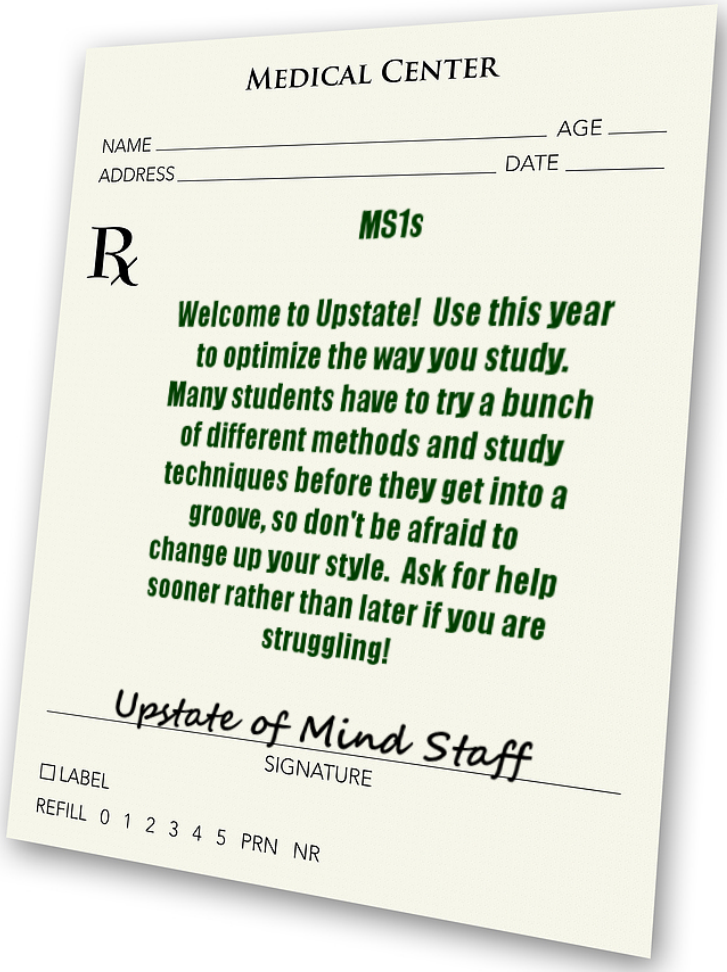
So the next morning when I come to see Mrs. U, her nails are beautifully shaped, cleaned and painted pink. She is smiling. 'Dr. B said that as soon as I can sit

upright in my chair, she will get her hair stylist in to cut my hair. And my nurse brought me some more nail colors too. Aren't they funky?' 'Your nails look beautiful Mrs. U,' I say, and it was a sincere compliment.

Since that day, Mrs. U hasn't asked for an increase in her pain medication. She still has occasional bouts of worsening pain. But she is happy with the explanation that these nerve pains have good and bad days. She has accepted pain as a part of her life and learned to deal with it. She has bigger things to worry about, like how to get her Kindle all wired and ready to use. Yes, Dr. B gifted her a Kindle when she noticed that Mrs. U loves to read but is unable to turn pages of a regular book because of weakness in her hands. Is she very rich, this Dr. B, one might ask? Well, in terms of money, probably not more than other doctors. But when it comes to generosity of spirit, she is a billionaire!

I have completed almost four weeks of my rotation now. Mrs. U considers me a good friend, though not as good as Dr. B, whom she worships. We discuss 'twilight' and vampires and werewolves. Her sacral ulcer is still quite deep; the bone is still visible, she is still on antibiotics. But we both feel that she is getting better. She has a great personality. 'I don't blame my husband' she says. 'I feel sad for him. He needed help, the Iraq war messed him up.' Her son's tenth birthday is coming up. She went down in her wheelchair and chose a card for him. She is almost bankrupt, so Dr. B has arranged for a lawyer to come see her.

So, does this story have a happy ending? Well, Dr. B is off service now and Mrs. U has an ingrown toenail. We tried to deal with it, but it is bigger than we are. We need help, so we called surgery (remember, no inpatient podiatry). The surgeon laughed at me – 'Doctor! We are training here to perform life-saving operations, treat hernias, gangrene, and cancers, not to do menial jobs like treating an ingrown toenail. And to tell you the truth, I don't know how to go about treating it anyway.' So, tomorrow I am going to speak with the social worker/case manager to see if they can request a podiatrist to drop by. Maybe I will give Dr. B a call, she always has some bright ideas.



A Physical Therapy Student, His Three-Year-Old Son, and a Play 'Doctor's Kit': A Unique Perspective on the Practice of Medicine

How can someone say "no" to Sam Schueler? I know I can't. That is why, when he asked me if I would be interested in writing an article for Upstate of Mind, I told him I was confident that I could come up with something. It has been four days since that fateful day- four days of not knowing what to write. What does a physical therapy student write about for a magazine geared toward medical students? I was about to concede to writing an uninteresting piece on the importance of the relationship between the physician and physical therapist. That is when my three-year-old son, Matthew, brought me his toy 'Doctor's Kit' and said, "Hey Daddy, let's play doctor." His suggestion, innocent and sweet, was ripe and full of meaning. I knew I had my topic. Let's play doctor!

Matthew insisted that I be the doctor. I agreed and decided I would perform a conglomerate physician/physical therapist examination. I grabbed my clipboard and put my patient on the examination table (living room couch). "Hi, Mr. D., my name is John DeNoyelles and I will be your student physical therapist." This is how we DPT students introduce ourselves during our clinical rotations. When patients hear the word "student," the look on their face is not exactly a confidence builder. "Tell me what is going on," I say. Without any prompting, he proceeds to tell me that his leg hurts and he points to his posterior thigh. "How long has this been bothering you?" Apparently, it started hurting when he and I were playing outside just 15 minutes before. "Is anything else bothering you?" He points to his knee. That also started hurting outside. "Anything else I need to know?" "My belly hurts," he replies. I now have the impression that my otherwise healthy son could go on all day and create more pretend problems. He is three years old, has no experience with being sick other than the common cold, and yet still knows how to catastrophize and create more fake symptoms. I am ready to move on with the evaluation but he beats me to the punch. "Use that one," he says, and points to the play stethoscope. "Okay," I say, "but before I start my exam, I need to know if you have any cultural or religious beliefs I should be aware of?" This is also something our program suggests that we ask our patients. He responds, "Yeah." There is an awkward pause. I am now anxiously waiting to hear what culture or religion my three-year-old has decided to join and how this new enlightenment will alter my play examination. "My heart," he says, and pats his chest over the corresponding anatomical location. I am

confused. Is he not only ignoring my question, but also telling me where the stethoscope goes? Even a pretend doctor knows where a stethoscope goes! On the other hand, is he having pain or trouble with his heart? We have a new symptom. This one is likely a red flag and I am about to get on his toy phone and call for a consult with his PCP. Before I have a chance, he pulls out an otoscope and hands it to me. “Use this.” I check his ears and everything is clear. He then reaches for a small bottle that reads, ‘Pills’. I should have seen it coming. My lack of experience blinded me to his intentions. I open the bottle and pretend to pour pills in his right hand, saying, “These are just sugar pills but they will probably make you feel better anyway.” He then holds out his left hand. I give in and pour some more air. He claims he feels better. Now I realize that my beautiful baby boy is an air pill-popper. Where did my wife and I go wrong?

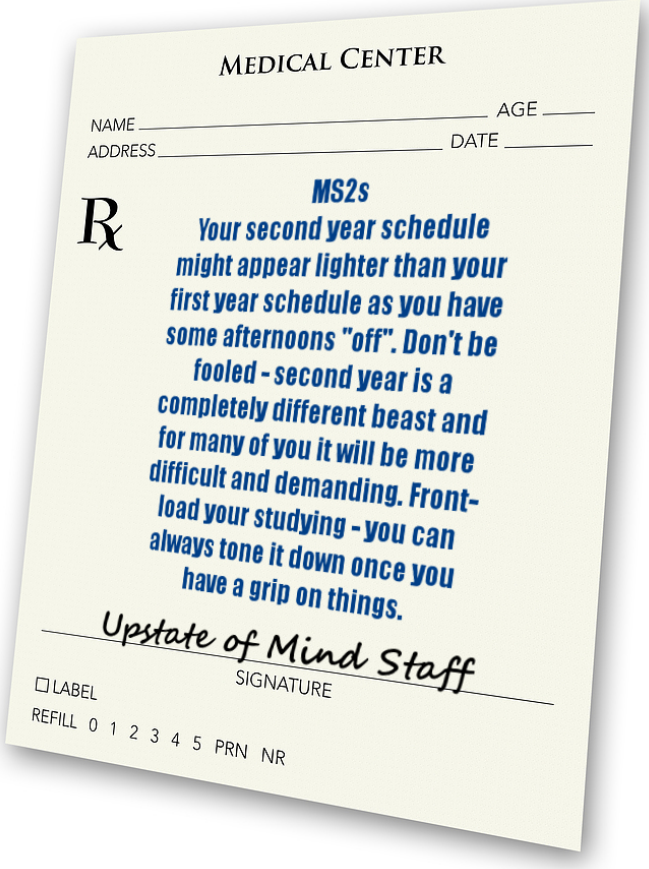
What can you take away from this story? Whatever you would like. I am not writing this to start controversy; I am only sharing an innocent interaction with some interesting conclusions. Perhaps it is my doing, but my son already knows how to pretend to act like a stereotypical patient. He also responded positively to a pretend placebo. I have a perfectly good explanation as to the findings of this interaction, but, alas, I am about to exceed the 1,000 word limit imposed on me by Upstate of Mind co-founder and editor, Sam. I am afraid of the consequences of not following his rules and regulations and I would rather not face his wrath. Before I meet my word limit, I will share three things I learned from this brief but powerful, pretend patient encounter:

1) You cannot be objective when treating your own family.

2) Giving the patient something they want makes for a successful interaction.

3) The role of a physician/healthcare provider is so well known to our society that even a three year old knows what to expect.

By John DeNoyelles
President DPT class of 2013



Ask THE Attending: Advice for the Medical Student

By Dr. Mitchell Brodey

Dear THE Attending,
My attending called me a F$%^&)+ moron today on rounds. I don't think he likes me…..
-Moroned in Syracuse

Dear Moroned,
Au contraire, your attending thinks you are smart. Remember when you were playing little league and the coach kept telling you "good try" every time you struck out while telling the best kid on the team how much he sucked? The only time attendings tell you are doing a good job is if we think you are a f*&&^%(moron.

Dear THE Attending,
Today was my patient simulation exam and I failed empathy…
-Heartless in Syracuse.

Dear Heartless,
That must make you feel so sad. I am sure you tried so hard and ….See how easy it is? I don't really care about you at all. Simulated patient simulated empathy. You don't have to actually give a crap, just ACT like you give a crap. You know, just like at your med school interview when you told them how much you cared for the undeserved of the world while thinking about what a much nicer office you were going to have than the putz interviewing you when you become a Beverly Hills plastic surgeon.

Dear THE Attending,
Why do we spend the most time learning about the diseases we are least likely to see…
-Bored to Tears MSII

Dear Bored,
Because the eye does not see what the mind does not know and the mind does not remember what the mind knows unless it is reminded of it and it won't be reminded of it when you need to be reminded of it because you never see it until you finally do see it if you don't KNOW it. Not take a test know it but know it like the address of the house you grew up in know it. Forever, just like Mrs. Woodrow told me in 6th grade art: Lettering is done with a pen; printing is done with a press. And I got a D in the class.

Dear THE Attending,
On rounds today I presented a patient with congestive heart failure and my endocrinologist attending wound up talking about diabetes…
-Failed in Syracuse

Dear Failed,
You have just experienced the subspecialist shuffle. This occurs when a subspecialist is confronted with a problem outside the specialist's area of expertise. This will be followed by a series of questions to the students in an effort to get back to the attending's comfort zone. The average number of questions is 3. You can amuse yourself by redirecting the questions back to the case and see how long you can keep the shuffle going.

Dear THE Attending,
My attending said my answer on rounds was wrong. I looked it up that night and he was wrong .What should I do….
-Wannabe Right MS3

Dear Wannabee,
My three favorite words from the

mouths of students are, “YOU were Right” This is because like most attendings we never hear this at home. Having said that, my second choice is that I learn something new. BUT acceptable references are not Kaplan notes, the Sanford Guide, or an unreferenced statement in a generalist textbook, or the worst Dr. so and so said… Bring me original data.

Dear The Attending,
My attending fell asleep during one of my presentations…
-Not Asleep in Syracuse

Dear Not Asleep,
It is not uncommon for attendings to fall asleep during third year student presentations. In contrast to students and residents we have no work hour restrictions. Unfortunately we are still trying to make up for those lost hours and long boring presentations are the perfect opportunity (especially if they involve power point). However, if your attending awoke before the end of your presentation, it was not too long and he/she will be grateful for the soporific quality of your voice.

Dear THE Attending,
I want to do a great job if I lose the lottery and have to work with you next year. What will you expect of me?
-SuckupMD

Dear Suckup,
I expect that you will show up and be kind and respectful to my patients. Being a great med student is somewhat more difficult .For that, you will actually have to help a patient. Not just out of a chair or with their socks (which is a good start), but solve a problem they have that I can’t… maybe with a good history or physical exam… maybe by staying up late trying to find the answer in the literature. That’s why you supposedly went into medicine, remember? You went into medicine to help people. That’s the reason you are on the ward and not the classroom, to read about the patients you see and answer the questions they raise. That is the real test; not the shelf; not the boards.

Lights, Camera, Fail.

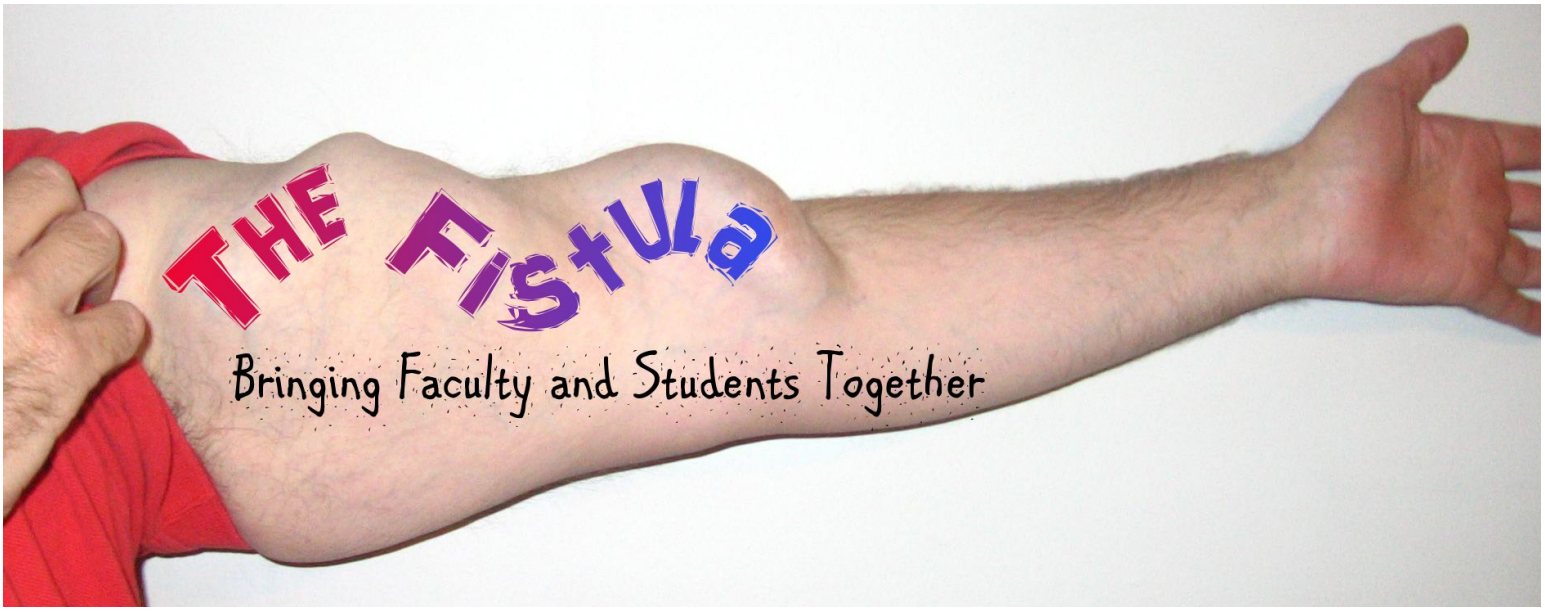
By: Samuel A. Schueler, MS3

Neurology was my first rotation of the third year. While rounding with the attending on the inpatient service, we came upon a patient with frontotemporal dementia who had been previously noted to have a wide-stanced, shuffling gait. This patient’s gait was of academic interest to the attending. He handed me a video camera and instructed me to tape the encounter. Specifically, I was supposed to film the patient walking. Simple enough.

Before our team approached the patient, he was sitting peacefully. His face was expressionless. As my team entered the room, I began filming from outside the room. After the attending talked to the patient and examined him, he got the patient’s walker. He asked the patient to use the walker and take a few steps forward. At this point, the patient became extremely angry and combative. He came very close to striking another medical student in the privates. He was trying to lift his walker off the ground and use it to attack the members of our team. He was cursing and yelling obscenities. The team tried to settle him down, gently restraining the patient so that he wouldn’t hurt himself or anyone else in the room. This went on for a few minutes. The commotion attracted a small gathering from the floor.

Throughout all of this, I was still video-taping. After the team finally got the patient to settle down, the attending walked out of the room, visibly disgruntled. I was filming him as he walked out of the room towards me, capturing his frustration. The attending looked at me and realized I was still filming, and said “SAM! What the h*ll are you doing!?!?”

I felt all the eyes on the room bare down on me. In hindsight, I wish I would’ve seized that moment to quote the movie Anchorman and exclaim, “Wow! That escalated quickly – I mean that really got out of hand fast!” Instead, I turned off the camera, five minutes later than I should have, and tried to look apologetic. In the near vicinity, a golden letter H floated upward and hovered by the ceiling, well out of my reach. And then it vanished.



Retiree Profiles

By Wasnard Victor

Dr. N. Barry Berg has worked at Upstate for 40 years, starting in 1972. Many of you first met Dr. Berg during first year in Gross Anatomy, and others may have had him as an advisor.

W: What is your fondest memory of Upstate?

B: It was about the 3rd or 4th year of the summer anatomy program and I was helping a student remove the brain, and one of the students gave a huge smile and said, "Wow, the human brain, that's what I'm here for, I'm here to study medicine, and seeing the human brain for the first time is so exciting!" Most interesting experience: In my second year here, 1974, I was teaching the cell biology course. Dr. Ames gave the first lecture and said, "My name is Ira Ames, and I'm from Brooklyn. Now that we know each other, I'm gonna get comfortable," and he took his tie off. I gave the second lecture, and said, "My name is Barry Berg, and I'm from the Bronx. Now that we know each other, I'm gonna get comfortable," and I dropped my pants! So with 150 people out there, no one said a word. They must have thought I was an idiot giving a lecture in my shorts. So I realized you have to know your audience, and when something is appropriate.

W: What brought you to Upstate?

B: I was very interested in learning electron microscopy. Upstate was awarded a large training grant for teaching electron microscopy, so it was a good time to come. Also, I had to get out of New York City. Upstate seemed like a good place to work and grow. Certainly wasn't the weather.

W: Words of Wisdom to the students?

B: Many years ago, Upstate was going through growing pains. I've seen students get involved in activities, but a lot of activities are very political. We are now at a crossroad of where education can go at Upstate, and I think students can be a very big part of that, but it takes an informed student, one who is aware of the entire process and the pluses and minuses. The student who listens and is willing to be constructive can make a difference. So be vigilant, be involved, and be very informed. We have a certain culture that we're second rate, but we're not…if you look at the kinds of outcomes, board scores, residencies, you can see that we're pretty darn good! People need to keep that in mind. In my mind the idea of involvement is not to tear down but to be constructive to move ahead: "You're not as powerless as you think, nor are you as powerful as you think."

W: Special plans for retirement?

B: Sleeping late, reading (history of anatomy), wine tasting, and traveling. In fact, if I ever become king of the world, I will outlaw Mondays, and mornings!

W: Is there a quote that you are known for?

B: I usually say to the students, “This is the thigh, that’s the leg, and there’s no such thing as a middle finger, it’s a middle digit.”

W: Anything else you’d like to add?

B: I’ve been very lucky. When I started here weren’t many opportunities for people in basic sciences interested in education instead of research. People should recognize that Upstate has put a lot of time into patient care and research; we should put the same efforts into education. When I first came to Upstate, around 1975 and was involved in teaching and admissions, there was a woman on the admissions committee with me, Dr. Ellen Cook-Jacobson, at a time when Upstate was going through one of its growth spurts, and she said to me: “One of the things that’s always a problem is that we don’t know who we are. We don’t appreciate the things that we do very well, and we’re always looking to be something we’re not.”

W: To Dr. Stearns: Any memorable moments you can think of while working with Dr. Berg?

S: Dr. B and I went on a field trip to Buffalo to talk to the director of the anatomy program there. An important part of this journey for Dr. B was the opportunity to stop at one of his favorite wine stores and to literally fill up a shopping cart with wine. It was there I learned that a cheap bottle of wine cost only $50. Who knew? Of course we have collaborated on many memorable "rectumectomies" over the years, each of which has been unique and all of what have been successful. On a more serious note...one could not ask for a more knowledgeable, supportive and witty colleague.

Dr. Chaitanya Haldipur has worked at Upstate for 39 years, starting in 1973. Many of you first meet Dr. Haldipur in the first year in the Physiology course, second year for Behavioral Sciences, and then again in the 3rd year Psychiatry Clerkship.

W: What is your fondest memory of Upstate?

H: The time when the department of psychiatry was moved to the Psychiatry and Behavioral Sciences building 15-20 years ago. I also enjoy it when our students do better than the national average in Behavioral Sciences and Psychiatry.

W: What brought you to Upstate?

H: I was impressed by the intellect and enthusiasm of the Upstate Faculty, Dr. Thomas Szasz, Dr. Robert Daly, and Dr. Eugene Kaplan who visited my university in England [Cambridge]. So I decided to join the department when they offered me a job.

W: Words of Wisdom to the students?

H: With the major changes happening here with probation, just know that all that will pass. The students should realize that the training you will receive is probably one of the best that you can get. I am really proud of the work that the medical school does as a whole; so don’t let the current state of things discourage you.

W: Special plans for retirement?

H: I will be at Upstate on a part-time basis, and conduct some classes when I am asked. Also I will be traveling.

W: Is there a quote that you are known for or have a quote that you are fond of?

H: There are many but I often think of the aphorisms of Dr. William Osler, especially: “A physician ought to be more aware of the kind of person that has a disease rather than what disease the person has.”

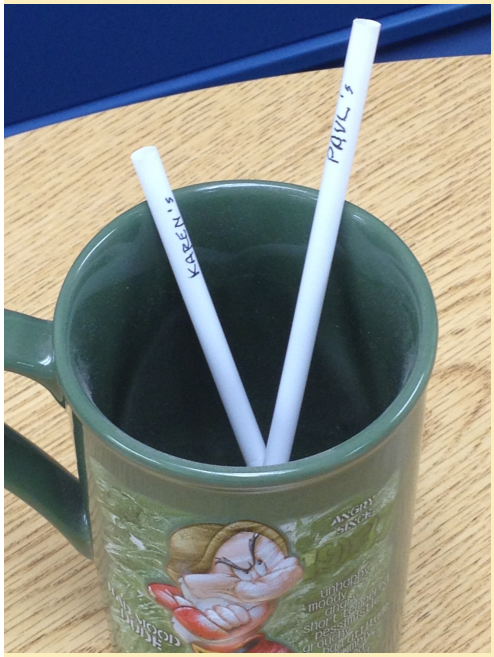
W: Anything else you’d like to add?

H: I am sure I’m not only speaking for myself, but just for anyone who is a teacher or adviser in a medical school, we always take pride in how our students turn out to be; whether they are humane in their approach to their patients. Be a good person in addition to being a good Doctor!

MLC: Behind the Scenes

Karen C. Kelly, M.S.

Everything one needs to understand the inner workings of the MLC program is captured in the following photo:



Yes, that short straw does indeed have my name on it.

All kidding aside (and yes, we do have a sense of humor), the MLC program is unusual in any number of ways and that includes the individuals who run it. When asked to write this article on the behind the scenes action of the MLC, I contemplated which direction to go. Should I tell stories, perhaps of the most inventive reasons for missing class that I have heard since I have been involved with the courses? Or should I relay through words or pictures (yes, Brian, I have them) some of the more memorable in-class moments? These ideas might have value at a later date, but in the end, I decided to focus on the aspect of the courses that go unseen to most everyone on campus – what it takes to run such a well-oiled machine.

I often joke with people that Dr. Shanley is the frontman for the courses and I'm the background singer - and that is exactly the way we both like it. There are a lot of moving pieces to a program such as this. The only way it appears seamless to students, we hope, is if everyone takes control in the areas they excel at. And for me, that is definitely not being in the spotlight. I give students a lot of credit for putting themselves out there, from taking the risk of being wrong and raising their hands in class to performing rousing birthday renditions. (Dan Harris, we will all miss the infectious joy you brought to every session. It brought a smile to many a guest faculty member's face, usually after the comment "what on earth have I walked into", which was never truer than on Halloween when Dr. Shanley, unknowingly playing the role of the "virulent pathogen", was phagocytized by a mob of student antibodies, a moment which will forever live on via YouTube).

Okay - back to the inner workings. Unlike the lecture courses in which the topics are fairly consistent from year to year, MLC is always in flux. As each case opens doors in a multitude of different directions, most weeks start out with an idea, a shell of a plan really, that over the course of a couple of days (or even hours) must be fleshed out and implemented. In the larger scheme of things, we try our hardest to not to recycle material, even if it was particularly compelling the first time around, both to keep the process fresh for the course directors and guest faculty, and to keep the cases current and diagnostic workup as up-to-date as possible for students to utilize as a learning tool. While the intent of reading these cases is to help model the clinical reasoning process that you all will have to employ when you encounter patients, we also want you to be aware of the latest technologies and how they will aid in the diagnostic process. As a result, the importance of imaging modalities, in particular, has been almost inescapable.

As the school year winds to a close, you might wonder what we are up to in the interim. In actuality, our planning process begins the day the prior academic year ends, and in some ways, is contingent upon what the other courses have plotted out. We survey the sequence of topics in a given unit, calculate the number of sessions we will have based on holidays and study days, and begin the process of reading cases from various medical journals in the hopes of finding current cases that fit the needs of the courses (i.e., offer a good discussion of the differential diagnosis for that case, open the door to questions of pathophysiology, integrate with what the other courses are doing concurrently if at all possible, etc.). The second-year curriculum is in some ways easier to plan as it has the "luxury" of month-long units focused on particular organ systems, as opposed to much shorter blocks in the first-year curriculum. Things might not always line up as closely as we would all like, but we do our best within the constraints of time and scheduling. Having a set date and time slot for sessions, while providing everyone with a sense of predictability, does not offer the opportunity to move content back or forward a few days to accommodate more ideal sequencing or a faculty member that needs to reschedule (in truth,

something we dread encountering along with a fire alarm during a testing situation).

We have been lucky over the years to recruit a talented group of individuals to speak to you all and discuss these cases. Our recruiting process from year to year is by referral (from former students or faculty) and from witnessing with our own eyes how the sessions proceed. I cannot help but imagine how intimidating it might be to walk into a room with 150+ individuals staring back at you with expectations that you can answer all of their questions; no matter how much you try to prepare someone for that, it can be unsettling. Everyone has their own style. We hope through feedback from course faculty and students that everyone can find a method that works for both themselves and the class. And I would be remiss if I did not single Dr. Shanley out in this endeavor as well. Not only does he have to stand up in front of you all and be an expert in kidney disease during the renal block, but during the pulmonary unit, he must get up to speed and be knowledgeable conversing about lung disease, and so on. Imagine after finishing your residency training in obstetrics & gynecology to come back to an academic environment and teach students about cardiology one month and neurology the next when your specialty is something quite different? Daunting, isn't it? Not every day is a triumph, but everyone does try their best. The same thing that is true for the workload of the course directors is also true for guest faculty - every year is a different case and something that must be prepared from scratch. There is no prior set of notes or PowerPoint to tweak or update. MLC is an investment of time for all involved, but when it works, we are all very proud to be involved with the program.

As we embark on a new academic year, the next few months will be a flurry of case selection, faculty recruitment, quiz writing (believe it or not, the least favorite part for the faculty as well), and sequencing. Not all of it is accomplished in one fell swoop. Many of the follow-up sessions for both courses are planned in real-time based on how the opening session proceeds and the questions asked by students (yes, that is what Dr. Shanley is writing in his notebook each day; let me dispel the rumor once and for all – it is not his diary). That fly-by-the-seat-of-our-pants method (ever notice how the quizzes are sometimes hot to the touch, that's the recently Xeroxed effect) gives us more flexibility than the other courses to adapt in real-time to the needs of the students and curriculum, but it makes a hectic and exhausting lifestyle for a program run by two individuals (and please don't even get me started on that academic marathon we call "renal month"). It is virtually a 7 day a week, 365 days a year enterprise, and we often times do bring the job and our work home with us for our families to endure (they probably can't stand to hear the words MLC any more than your friends and family can at this point). There is no back-up coverage, thus you will see more of the two of us than you might like, but we also like to think that it brings a certain sense of consistency and comfort to the environment. We know where you all have been in your curriculum travels and try not to retread old ground. Although, yes, we know lupus has come up again…and again…and again…and again. But it's not like you couldn't get the same reinforcement from watching "House", which has its own humorous outtake titled "It Could be Lupus" about how often it comes up in the differential… but is so rarely the answer.

As some of you graduate and others of you move on to a life without MLC, I hope you will remember the good times and say hello when you see me in the hallway. I promise unless you seek me out in an auditorium, I will not have ParScore forms in my hands, so there is no need to recoil! (And yes, I probably do still remember your name as I suspect you'll remember mine and Shanley's for years to come in your dreams, nightmares, or hopefully, in a patient room when something you learned in MLC allows you to make a difference in someone else's life). And here's a final reflection: If you want to remain in the shadows like myself, it is not advisable that you droop us with Hawaiian leis, present us with a Snoopy valentine as you shoot us with a cupid arrow while the song "I Can't Take My Eyes Off of You" plays in the background, dress up as the two of us for Halloween, chase us around with a mistletoe headband, or carve us a Shanley-head pumpkin or the like as it tends to make quite an impression.

Crawling on your hands and knees across the floor of the auditorium while dressed in a gorilla costume also goes against anonymity. Perhaps that costume could have been loaned to Dan, Ryota and David for their engaging "in the mighty jungle…" rendition to the first-year students…

Until we meet again.

A Re-Print Identified by Dean Cleary and Passed Along from Dean White - Enjoy!

Choosing a medical specialty

Epiphany, where are you?

Jenna L. Thomason, BS

The author is an MD/MPH candidate in the Class of 2012 at Emory University School of Medicine and the Rollins School of Public Health at Emory University.

> **epiph·a·ny** *noun* \i-ˈpi-fə-nē\: (1) : a usually sudden manifestation or perception of the essential nature or meaning of something (2) : an intuitive grasp of reality through something (as an event) usually simple and striking (3) : an illuminating discovery, realization, or disclosure.
>
> —Merriam-Webster Online

Oh Epiphany, where are you? I attended a year and a half of lectures and absorbed as much information as possible about every molecular, biochemical, and cellular mechanism imperative to maintaining the body's homeostasis. I spent countless hours in the basement of the medical school learning anatomy from my cadaver (whom we fondly named "Arnold"). I have studied every organ system—integumentary, musculoskeletal, respiratory, lymphatic, cardiovascular, endocrine, genitourinary, gastrointestinal, nervous, reproductive—as well as the hundreds of disease processes that cause these systems to go awry.

I wielded a blade like a surgeon. I walked the halls of Grady like an internist. I delivered a baby like an obstetrician. I held the hand of a dying patient as a palliative care provider. I distinguished macules from papules and patches from plaques on my dermatology rotation. I treated everyone from tiny babies to pregnant ladies to the elderly as the understudy of a family physician. I tested each reflex and every nerve during my neurology clerkship. At the side of a radiologist, I learned anatomy that Arnold couldn't teach me. I cared for many minds on psychiatry and many tiny bodies on pediatrics. I have witnessed the full range of disease etiologies, including genetic, developmental, toxic, infectious, traumatic, metabolic, chemical, neoplastic, and degenerative. I have studied the vast spectrum of treatment options, including behavioral, pharmacologic, and surgical, and I understand the rationale and application of each to the above disease etiologies. All this has led me to the most difficult professional crossroads of my life: Where do I go from here?

The decision to pursue medical school was the easiest decision that I have ever made. I've never known a stronger desire than the one that I felt (and still feel) to become a doctor. I wanted to make the commitment to caring for people and possess the knowledge to do so. I hardly knew what I was getting myself into, but I couldn't wait to get started.

So how did the simplest decision turn into the hardest one? And when did life become a multiple choice test? All of sudden I have to chose between: (a) kids; (b) adult males and females; (c) females only; or (d) both (a) and (c). I have to decide whether I want to interact with patients or examine their pictures or inspect their pieces (in the form of pathological specimens). Do I want to know a little about a lot or a lot about a little bit? I have to factor in lifestyle, inpatient versus outpatient, academics versus private practice, seeing mostly healthy patients versus seeing mostly sick patients, skin versus bones versus eyes . . . and it's more complicated than those aforementioned molecular, biochemical, and cellular mechanisms ever were.

So, dear Epiphany, why are you so late? You were supposed to make this an easy decision. Is this punishment for all of those days during first year of medical school when I snuck into 8 AM lecture when the minute hand was a few degrees past 12? I thought for sure that you would be here by now. I was counting on you. I'm starting to think you're not coming. Maybe you never were.

Contrary to my idealistic expectations, many medical students—if not most—end up marking you down as a "no show" in our appointment books. The truth is, there may not be one single specialty that's right for any of us. If we are having trouble deciding between two or three, any one is likely to fit roughly equally as well as the others. After spending many months agonizing over this decision, I have finally found that Jenna the pediatrician is not so different from Jenna the dermatologist or Jenna the geriatrician—because I will not be defined by the type of patient I see, but how I see them.

Stress over what divides us is temporary, but preserving what unites us—commitment to lifelong learning, medical ethics, and our patients—is unceasing, and is what earns all of us the extra letters that follow our last names.

Epiphany, we meet at last.

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Classroom Chronicles

A Missive

from Dan Harris '14

The College of Medicine Class of 2014 is making the transition from being second-years to third-years. As far as transitions go, this one is pretty special. We leave the lecture and books behind as we step into the intimidating, invigorating world of hands-on, clinical learning.

I remember the beginning of first year, thinking about the coincidence of it all. We all set down for the first MLC. I looked to my right – no idea who was sitting there, but let's say it was Chris Ma – and said, "Hey, I just met you. This is crazy!" I looked to my left – no idea who was sitting there either, but let's say it was also Chris Ma, for the hell of it – and said, "Well, hello there. My, it's been a long, long time."

I remember the end of first year. I thought about the intersection of all our lives, in our own season and time. Let's say we had all been roots in the beginning. We pooled our experiences like water and starting growing up into the world of medicine. Can you imagine a stump - one that's growing - with each little stump piece pulling each other upward? Hold that thought. Let's look back on the last day of MLC I and the Closing Hymn for First Year:

Hymn! Hymn! F*** hymn!

Oh, sorry. That's not the one. That would be the Hymn to Dave Gibbs. Here's the Closing Hymn for First Year:

As first year comes and first year goes,
The things we know are hard to show.
There's more we know and less we don't,
But what we don't, most we won't.

So, for the prayers, here's a prayer;
And for the players, here's a dare;
And for the thinkers, here's an oath;
And for the drinkers, here's a toast.

May our dos not become don'ts.
May our wills not become won'ts.
When our minds may not be there,
May we find our hearts still care.

I remember sitting down to write the Closing Hymn for Second Year. I thought about the day when "today" would refer to our last day of MLC II. If you'll remember the stump we started during first year, this would be the day we start branching. In the very end, our collective influence will be the limbs we all stepped out on, leaving Alumni Auditorium on April 23, 2012. Hold that

thought, again. Let's deal with another metaphor for a moment. This year's hymn is about being thankful that we aren't days. Here's the Closing Hymn for Second Year:

Today's today and it's funny how
Today's been when and now's now.
A day's day is the time Time's due
To meet the day that's passing through.

Days may not meet more of their kind;
Mayn't ever look. May never find
The day before or the day to come.
There's a door to To, and a door from From.
There's a room with room for the day that day.
'Til the time Time shows the way away.

Yet, you and me, we met and meet.
Today's today's unsweet and sweet.
I met today as I once met you.
We'd come from From, Now we go to To.

Anyway, I hope that I run into you, or Chris Ma, or Dr. Shanley, or another Chris Ma, sometime soon. We'll take a cup o' kindness yet for auld lang syne.

I'll remember medical school in many ways, I'm sure. So far, the most common etiology behind my memories is MLC. I'm thankful that there are memories that the whole class shares because Dr. Shanley made us show up. Dr. Shanley is a part of our stump. Now, all of our branches become roots leading to a new stump. I'm branching to help out with the Binghamton stump. Dr. Shanley's branch heads off to wait for the incoming class – in some clump of dirt, I guess. Chris Ma might have a bunch of branches since, apparently, he's omnipresent or something.

The Reanimator

By David M. Gibbs

After life's fire has dwindled,

She will go to him.

Strangely still the Reaper's list

She has swindled.

Upon the cold, dreary slab

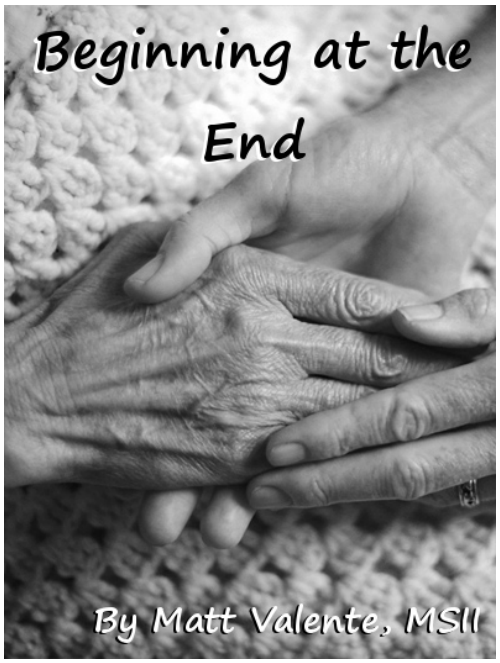
Their lips will meet in immortal kiss.

For their love none could break,

Not even death's painful stab.

Worse to come than mournful sorrows

When the dead in life retake.



As I walked down Lancaster Avenue, toward the 10th floor of University Hospital, thoughts raced through my mind in rapid succession. What will it be like? What if the patient is unresponsive and I have nothing to say or do? What if the patient is responsive and I have to say the right thing? What sort of consolation can I possibly offer to someone expecting to die by dawn?

A half hour earlier, I had responded to my first call as part of the End of Life Companions (EOLC) program, started by Pat Knox, a palliative care nurse at Upstate. The purpose of the program is to provide imminently dying people with company in their final moments, so that they will not die alone. These patients often have no available family, or those that they do have cannot reach them in time. For others, the dying process takes days, and family members suffer long and emotionally draining vigils. In these cases, the EOLC members provide much needed respite.

When I arrived at 10G, I

chatted briefly with the patient's spouse and was touched by the flood of gratitude and relief that he expressed. He was noticeably drained from a sleepless night by his wife's side. His reaction to a stranger's helping hand showed me the significance of the spirit, and not the science of medicine. By simple virtue of character and empathy, we each have the opportunity to help fellow humans stay afloat even in the darkest of waters. Later, as I sat with the patient, I began to understand that none of my original worries mattered. For me, the prime lesson of the EOLC experience has been that there is no right thing to say or best way to console people as much as we would love for there to be. Death and grief are inevitable parts of the human experience, and as healthcare professionals we must learn to accept these entities to provide the best care and compassion for our patients.

With the close of twilight, my shift ended and I trudged through Syracuse University en route to my beloved bed. Tipsy college students sauntered by with boisterous revelry as they celebrated the starts of their weekends, and figuratively, their lives. The contrast between this scene and my night at the hospital echoed the first rays of morning light peeking over the campus. I am grateful for the EOLC experience, because through death it showed me how we all have the chance to do the most with life.

California

By: H. Stephen Reinheimer, MS1

I remember
walking, holding
Dad's hand
He was so much taller
My protector
God
He knew everything
He could yell louder
than anyone
He was scary
He was smart
He was
Dad

He could fix anything
Mr. Fixer, they called him
with an accent
Dad always provided
Dad worked
and worked
and worked

I missed him
but I didn't know
how much

I moved
away

For a long time
Far away

to Califorina

Dad moved away
too
Far away
He moved
away

to Alzheimer's

Slowly at first
Then faster
and faster
Some things he cannot fix

I came back

When I last saw him we talked
He told me about his trip

to California

The job he had there,
a trip in the car
a story I knew took place in
New Jersey

Yet, something about me,
the son from California
fired a neuron
that was still working
and his story
was a California sotry
an attempt to be
close

I held his hand
Not so strong
I'm taller
He's less
tall

I went away
and I came back

Dad went away,
but he will not
come back

We can only meet
in California

Written in remembrance of Kurt Reinheimer (1/1/1926 - 4/28/2012)

What's in the Food in Worcester, MA?

UMASS Medical Students Mitchell Li, Adam Chin, and Matt Dewolf started WooFood, a nonprofit, to make it easier for the community to eat healthy. I had a chance to ask them a few questions about their operation.

Introduce WooFood for us.

WooFood (which was supposed to be short for "Worcester" Food but is commonly confused for something Korean judging by the junk mail we receive) is a unique nonprofit that certifies restaurants that not only provide healthful choices, but make them the easy choice. In the book In Defense of Food, Michael Pollan refers to the "American Paradox" - the idea that more people think about eating healthfully in the U.S. than anywhere else in the world, yet we have astronomical rates of diet related chronic disease. WooFood believes that people should not have to think all the time about making their food healthful, so WooFood strives to make it easy. Right now, in order to get a meal that's not hazardous to your health, you essentially have to be "that" customer, asking: "Go light on the cheese?", "Can you make that whole grain?", "Could you add some more vegetables?"

What is a non-profit organization and how did you guys go about starting one?

A 501(c)3 non-profit is a tax exempt non-governmental business that exists for public good. Hospitals and health care make up the largest monetary share of the nonprofits in the United States. The main characteristic of a non-profit is that any income has to go back into the mission of the nonprofit, not to shareholders. We didn't intend to create a nonprofit from the start - but realized it was the best way to go in order to handle funds and maintain our autonomy from any other given organization. As for how? In order to become a non-profit, we first made WooFood into a Corporation. From there, we registered with Massachusetts as a non-profit company, then applied to become a 501(c)(3) through the IRS, which allowed us to be officially tax exempt.

What was the biggest challenge in getting started?

Waiting for nonprofit status! Actually this would have been a lot harder without Matt Dewolf's sister, Courtney Matsuishi, who is a lawyer at an LA law firm helping us out pro-bono. Courtney has also helped us tremendously with the regulatory stuff! The biggest challenge was sitting down to actually write the criteria. While we knew that we wanted to make healthful options more readily available and easier to order, it was incredibly challenging to sit down and think of the enormous number of ways to make this happen. It had to be flexible enough to be able to become incorporated into any restaurant

from fine dining to a blue collar diner (Worcester holds the claim as the birthplace of diners!). Also, we had to be sure that it was practical for restaurants to put these changes into place.

What has been the biggest surprise thus far?

How amazingly receptive the whole Worcester community has been to the program - especially the hospitals and other physicians. Every day we are surprised with a new opportunity. For example, a local chef who also teaches at the vocational school has offered to start a WooFood test kitchen.

What advice would you have for an Upstate student wishing to reach out to local restaurants in hopes of getting them to offer healthier selections?

Start a WooFood chapter! A lot of the groundwork is done - you would be a branch of a pre-existing nonprofit, complete with certification criteria (the result of months of development), a logo, and even a training manual. There really is no reason for WooFood not to spread - and it looks really good to the community coming from medical students.

Are you guys planning on working with Woofood for the rest of your careers? If not, what measures have/will you put in to make sure the effort is sustained?

We're all planning on staying involved in some way - we've put too much work in to let it go! That being said, we realize our role will not always be to maintain the day-to-day operations (especially if we branch out) - so we are putting heavy effort into training and engaging diverse community members including members of the Massachusetts Medical Society Alliance (composed mostly of spouses of physicians in the MMS), motivated wait staff from different restaurants, and even patients from UMass Medical Center who have made it a priority to eat more healthfully. We've also developed strong ties with hospitals, the Worcester Department of Public Health, a group called Pioneering Healthier Communities (a collaboration between the YMCA and the CDC), and numerous other community organizations. Even if we were to quit medical school and do this full time - there is no way we would succeed without this collaboration!

Mitch - I've always intended public health to be an integral part of my career. Since obesity and inactivity is overtaking tobacco as the leading actual cause of death in the U.S., WooFood satisfies that. After dabbling in health care policy through organized medicine, I am realizing that working through WooFood is a much more efficient outlet for this. It's very rewarding to bypass the politics and create tangible change!

Matt - Ever since I was in kindergarten working out has been a passion. Think of a 6-year old doing curls then asking people if they could tell I worked out. As I grew up, I realized that fitness, nutrition, and helping people are what I want to dedicate my life to. I also developed a passion for anatomy and physiology, prompting me to study exercise physiology in undergrad. Medical school and WooFood have been great ways to make my passions into something tangible, and hopefully help other people! With that being said, I do plan to continue working with WooFood for the rest of my career.

Adam – As a third year student, I have seen how pervasive the effects of obesity-related disease are. Already, I've seen patients lose toes, suffer heart attacks, and face crippling disability – all because of a condition that can be prevented and modified before people end up in the hospital. In this sense, it is our responsibility to address these issues where they take root and not after they have already taken their toll. Because of this, I know that WooFood and prevention will always be parts of my career regardless of what field of medicine I choose.

What kind of doctors do you want to be? How has/will this experience with Woofood help your future practice?

Mitch - I'm planning on emergency medicine. It's been a bit of a tough decision between that and primary care (given my propensity for preventive medicine) but in the end, I decided that I really enjoy the clinical aspect of EM and the schedule would better allow me to pursue WooFood. A lot of the skills are surprisingly transferable though; especially in speaking with the restaurant owners. It's really interpersonal skills, and is really the same as motivational

interviewing with patients.

Matt - I want to be a great doctor. Ok, well that's my answer when my grandmother asks me. I recently realized how much I love musculoskeletal anatomy and it is pulling me toward orthopedic surgery, but I am open to anything at this point. WooFood has given me invaluable skills about running a business and all the things you have to think about. Specifically, it has helped me learn to balance looking at the big-picture versus the day to day options.

Adam – I am still grappling with the question of which field of medicine to pursue, but cardiology is currently at the top of my list. The biggest skill that I will take from WooFood into the clinic is the ability to talk frankly about healthful eating. Doctors are often unsure about how to address diet with patients, but it is one of the most important discussions we can have. Whether I choose cardiology or any other field, I will leverage what I have learned from WooFood to have those difficult talks and guide patients to more healthful lifestyles.

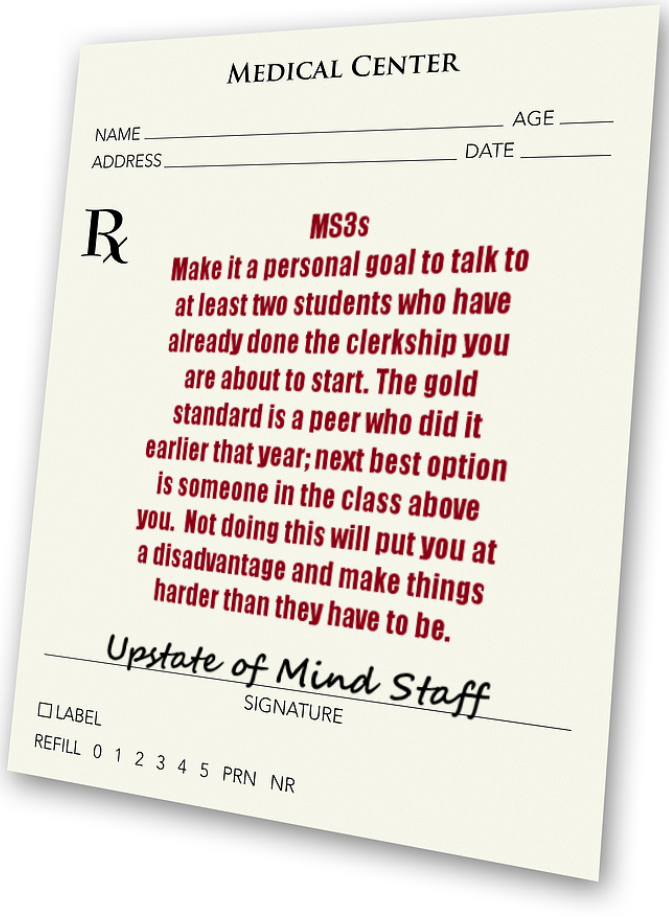
What is the funniest thing that has happened along the journey of starting/running Woofood?

Probably this picture:

Matt - Top left (red shirt) Adam - Bottom left (blue shirt)
Mitch unfortunately (or fortunately?) missed this photo shoot.

Want to get in touch with the WooFood staff? E-mail them at info@woofood.org, or get in touch with the Upstate of Mind staff and we will put you in touch.

Interview by Samuel A.Schueler, MS3



Narcolepsy Outbreak Sweeps Upstate

By David M. Gibbs, MSI

SYRACUSE, NY - The mood is somnolent today at Upstate in the wake of a narcolepsy epidemic that has left the campus sleepy and desperately wanting a nappy-poo. The haunting snores of dozens of sleeping students reverberate through Setnor and Weiskotten halls and chill any passerby to the bone.

The CDC, which has been dispatched in response to the crisis, is baffled as to its cause. “We just don’t get it,” responded Dr. Richard Wilson, team leader of the CDC’s acute response force (ARF), “there just doesn’t seem to be any useful pattern. Students seem to fall asleep mostly in the morning classes, but also after lunch. They also seem to fall asleep more the Tuesday after a Monday test and just about every Thursday. We have no idea what is going on.” The official could not elaborate further, but stated, “Although all classes seem to be afflicted, the Practice of Medicine and Medical Literature Curriculum courses seem to be ground zero for the outbreak.” Students unafflicted by the illness are frightened and many have chosen to watch lectures online.

Not everyone is hurting from the outbreak, however; Starbucks, Dunkin Donuts, and Bruegger’s Bagels on Marshall Street have reported record sales as half-awake students attempt to stave off sleep with large volumes of caffeine. In fact, Starbucks is doing its part to help with the crisis by releasing a limited edition “Mud Roast” (named after its resemblance to the bottom of Onondaga Lake) containing forty times more coffee beans than regular coffee. They boast that it will keep any student awake “indefinitely” and may provide the key to solving the outbreak. CDC officials are considering implementing the drink as part of their treatment plan.

SEE NEXT PAGE FOR PICTURES

Before They Were Medical Students

MSI Dave Gibbs, 18, trying very hard to look cool

MSII Class President Dan Harris still in baby diapers

MSI Ryan Smith at birth

MSIII Rob Handzel in his future life as a baby elephant

Longtime friends and MSI's Nicole Cifra and Kelly Cummings