It is a mistake to regard age as a downhill grade toward dissolution. The reverse is true. As one grows older, one climbs with surprising strides.

~George Sand (1804-1876)

Finding Meaning in Medical School and Medicine

Mark Fitzgerald
Medical School Class of 2013

A number of years ago I was in high school working a summer job as a lifeguard. On a particularly quiet day, I was watching an empty pool when a woman in her seventies struck up a conversation. She asked me about my career aspirations, and I told her about my interest in science and someday becoming a doctor. She began telling me a story that took place sixty years earlier, when she had been a young girl skating on a New England pond with friends. As she ventured out to the middle of the pond, she heard a noise like TV static, followed by a thunderous crack. In an instant she was entirely submerged under the ice. She recollected being disoriented and paralyzed by glacially cold water. She could still vividly remember seeing above her the blurry, shadowy figures of bystanders lying on the ice near where she had fallen in—unable to reach her. She said she felt hopeless struggling. She remembered feeling like her whole life had been snatched away in less than a second, terrified and angered at how unfair it would be to die. Moments later, she heard a muffled splash and saw a burst of bubbles around her; she felt hands pulling at her, hoisting her out of the icy lake. A local physician had jumped into the lake to save her since no one could reach her from above the ice. She explained the physician wanted no recognition after rescuing her, but to her that doctor will always be her “knight in shining armor.”

Medicine, I think, is a profession of icy lakes and knights in shining armor.

Many medical and nursing students remember their community health clerkship well. As part of a student’s training at UMass, the clerkship presents an opportunity to be immersed in a field of medicine in various community settings for two weeks. I selected geriatrics and had the privilege of being mentored by Lois Green, a long-time benefactor and educator of Massachusetts medical and nursing schools. She was a woman whose passion for teaching and involvement in community medicine was well known. She taught me a tremendous amount, using her own diagnosis of incurable breast cancer as a teaching point about caring for patients approaching the end of life.

Several times, she emphatically mentioned her belief the geriatricians she knew were “the knights in shining armor” of medicine.

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During my second year, I participated in an optional enrichment elective called The Senior Patient Navigator Program. Students are paired with an older adult patient in the program whom they ‘navigate’ through their medical appointments over the course of the year. The first time I met the patient I would navigate, I noticed how the man’s stiff black and white collar hung loosely around his thin neck. This was an odd contrast to his distended belly that prevented him from sitting up when my preceptor and I finished examining him. He had many physical signs of anemia and a belly full of ascites, but little else of note on exam. He was a man who had led a simple life of few indulgences, who valued the love of his community, sister, and dog. His past medical history was as unremarkable as a person could have; he felt he was overall healthy, just a little too sedentary and a little too much salt in his diet. During that visit, the hematologist expressed concerns about the patient’s liver health, remarking that lab-work would need to be done.

A week passed when the patient had an appointment at his primary care physician’s office where it was explained he had liver cirrhosis and hepatocellular carcinoma. I had the privilege of witnessing one of the most compassionate and meaningful conversations of my medical school experience during that visit, a conversation facilitated by Dr. Gary Blanchard, a geriatrician at St. Vincent’s Hospital. A subsequent visit to a specialist would confirm some of the hardest news; the patient was not a candidate for transplant or cancer resection, and his care from that point onward would be palliative. Continued on page 2

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Melting
Beth Terhune
GSN GEP1

The sunlight filters over your hands
Agitated while the rest strains toward invisibility.
You don’t like making waves.
I’ve noticed.

Two weeks of spotlight after
A lifetime of making others shine.
Unwilling to counter interventions
But reluctant to receive them.

Nothing by mouth.
Momentary gains in self-reliance
Snatched away by new tubes or tests.

Nothing by mouth.
In desperate moments
your fingers seek out
Not human comfort
But the menu.
Caressed and savored
Then frayed by anxious fingertips.
Two weeks of waiting.
And the tray at last arrives.

And is left untouched.

One bite missing
From the magnitude of your desire.

There is no alarm generated for this.
Just a slip tossed aside.
Crumpled in despair.
Lying.
Not to be depended upon.
Words that say one thing
And mean another.
Again.

Oatmeal raisin.
Not chocolate.

You don’t like making waves.
I’ve noticed.

But in this moment, you are held
Across the room
In the hall
Within elevator doors
Through basement corridors.

A small chain of hearts and hands
reversing the tide of your disappointments.

And quietly delivering.

The sunlight filters over your hands
now quieted in contentment.
Crumbs tidied carefully
So that no fuss is made.

Six more hours before picking up
Bags and papers and feet... and life outside these walls.

Finding Meaning in Medical School and Medicine
Continued from page 1

Only a few days afterward, I accompanied the patient to another appointment, prior to which the patient remarked that he didn’t feel well. As we waited, I offered to take a history and do a cursory physical to pass the time and determine why he was not feeling himself. On exam, the plantar surface of his right foot was entirely necrotic. He was admitted to the hospital and had urgent surgery that same day: a below-the-knee amputation for necrotizing fasciitis.

In two weeks, the patient I knew had gone from being self-described as healthy, to a person with liver cirrhosis, inoperable cancer, and a right foot amputation. He and his family had taken a plunge into an icy lake few people would be able to fathom, let alone stand. I had the privilege of being by his side, assisting with his care, and learning from him through his ordeals over the subsequent several months. I watched as the patient’s life was turned upside-down, but remarkably he continued to wade through tragedy and challenge with stoic tranquility. He faced the end of his life with a calm serenity, saying all he wanted was to fade away and die at home, surrounded by his community. In July 2011, the man whom I had honor of learning from for seven months died at home while on hospice.

Medicine, I think, is a profession of icy lakes and knights in shining armor.

Medical students spend a significant amount of time during their first two years learning from a clinician called a longitudinal preceptor. Dr. Arthur Church, an internal medicine doctor and hematologist, was my preceptor. On many occasions, he would be the one to care for hematology cancer patients from their diagnosis through their cancer treatments. His patients would refer to him as their “hero” and “knight in shining armor” more often than I can remember. It was in his office I started to appreciate my affinity for working with senior patients, one that would grow substantially as I began working with geriatricians and palliative care physicians. A mentor once told me that to be happy as a doctor, you have to practice meaningful medicine. I find meaning in caring for a population that carries a sort of wisdom found only with maturity, a lifetime of experiences and stories they are eager to share, and a population whose complexity of medical problems makes finding the solutions even more rewarding.

As nursing and medical students, we go through our training and find no shortage of patients who will have the ice break beneath them. Whether it is an unexpected diagnosis of cancer, permanently debilitating injury, worsening incurable illness, or a patient struggling with the death of a loved one, there will be many times we as nurses and doctors will have the privilege of being the person that plunges in to help them.

Every field of medicine has clinicians who jump in to help, and one of the most important goals of our training should be to find the mentors whom we admire and the field of medicine that inspires us. For me, it is geriatricians and palliative care clinicians; those caring for the most senior and most complex patients are the ones who evoke the imagery of the Arthurian knights of old. I hope everyone has the opportunity to find such mentors during their training. For those searching, I hope I’ve provided a suggestion of somewhere to look.
I followed a lovely 94-year-old woman for about a week when she was admitted to the hospital this past summer; I was on my inpatient medicine rotation as a third year medical student. ‘J’ had been doing well and was in good health when she presented to the hospital with an episode of syncope at Beaumont, an adult care facility during the day. She was worked up and it was determined that a recent medication change was the culprit. She was all set to leave and I felt good about figuring out the case with the team and completing her discharge paperwork.

I headed to her room on 3 East to give her the news of her imminent discharge from the hospital; she was alone in her room, all smiles. I told her in a loud voice, because of her poor hearing, that she was going home and her granddaughter was on the way. She was delighted at the news and stated so, and then suddenly slouched over in her chair. I felt immediate panic rise up in my chest and as it was my first week on my first 3rd year clerkship I instinctively grabbed her wrist to feel for a pulse, as that was all I could think to do. I noticed it was quite slow and counted - 38 beats per minute; her pulse was dropping lower while my own sense of panic was rising and I could feel the heat rising in my face. In my next move with no real reason, was to transfer her to bed and lay her down. She was a frail elderly woman and I thought she could not be that heavy. I awkwardly slipped my hands under her arms in a crouched position and gave a great heave. As I stood up I felt her sliding through my arms down to her knees on the floor and I felt the situation was doomed. I shouted for the nurse. She ran in to find me pinning J’s back to the side of the bed with my shoulder while trying to lift her from the ground. The nurse ran over and the two of us quickly raised her into bed. I had no opportunity to feel embarrassed at this point, but later, that feeling would settle into the space vacated by my panic from earlier. We were able to call a rapid response, bring the appropriate personnel into action and J stabilized.

Luckily, we had her on telemetry and we were able to find the culprit of this episode in the printout of her heart rhythm back at the nurse’s station. We diagnosed her with sick sinus, also known as tachy-brady syndrome and she was given a pacemaker. There was a complication with the general anesthesia she was given for the procedure, which lagged in her body for a couple days, leaving her very agitated and hostile which is quite different than the personality I had come to know. In the end, she recovered uneventfully and was back to herself and ready to leave the hospital, for real this time.

As she prepared to leave, I realized that it might be a good opportunity to touch on a subject that perhaps nobody had beforehand as she was listed as a full-code. So, I approached the subject of end-of-life planning with her, a subject I care a great deal about, and it became clear that it was a subject she didn’t feel permission to really think about. When I asked her if she had thought about it, she replied that she was only “staying around” because her granddaughter, and primary caretaker, was very much attached to her and she couldn’t bear the idea of disappointing or upsetting her. I was, again, amazed with J’s unconditionally giving personality.

Her daughter, granddaughter, and great-granddaughter all arrived together to bring her home. It was amazing to look at these four women representing almost 100 years in one room. I did have the opportunity to speak with J’s granddaughter privately about end of life planning, and I did my best to support her by perhaps being the first to give her some sort of permission to think about the end of J’s life and to approach that subject without guilt. She admitted it was something she didn’t like to think about and a subject she had been avoiding but one that needed attention. She felt, maybe after seeing her suffer some of the adverse effects of the anesthesia just a couple days prior, that she was ready to approach this subject with her grandmother.

I met J and her granddaughter a month later for their follow-up appointment with cardiology to check on the pacemaker. They both were cheery and doing well. J back at Beaumont spending days with her friends, and her granddaughter back to work juggling the care of her grandmother and her own family at home. While J was at the nurse’s station having her vitals checked, I asked her granddaughter if she had spoken with J about what had happened at the hospital a few weeks ago and what her grandmother’s thoughts were. She meekly admitted that she hadn’t found the opportunity yet. I, in turn, took that opportunity to remind her that there was no pressure or expectation from my part but that I was there to support their choices. The appointment went well and J’s pacemaker had solved her problem. It was keeping her heart rate above 60, a range that keeps her conscious and vigorous. I walked them out and we exchanged farewells giving each of them a hug and wishing them the best. I squeezed the granddaughter’s arm and she squeezed back, and in that wordless moment I knew she felt my support and would find her own way.

Let Me Die Peacefully

Susan Mugford
GSN Masters Student

If you were dying
And no one understood
But you just kept trying
And it did no good
You wanted to yell
Listen to me
You got up and fell
Do you see what I see
Others say there is no one
There
What are you reaching for?
Doesn't anyone care
I'm at heaven's door
Please help me die in peace
Tell me you'll be OK
So I can close my eyes and pass away.
**New Leadership**

**Kelli Paice** is a rising second year medical student hailing from Mansfield, Massachusetts and the University of North Carolina at Chapel Hill. She is looking forward to working with Julia and the GIG faculty mentors to develop another great year for the Geriatric Interest Group in the fall. Kelli joined GIG hoping to gain a better understanding of how to better serve older adults in primary care and has enjoyed what she’s learned through seminars, service, and the Navigator Programs. At UMMS, Kelli is also a Rural Health Scholar, an admissions ambassador, and a member of the Pediatrics Interest Group. This summer Kelli will be working with Dr. Jennifer Tjia at UMass, doing research through the MSTAR Program.

**Julia Randall** is a rising second year medical student from Cambridge and Westborough, MA. She graduated in 2009 from the University of Wisconsin, Madison with a degree in International Relations; then decided to go back to school "for science." She participated in the Geriatric Interest Group and Navigator program this year and found them amazing ways to learn more about caring for older adults, and to get time to spend with and learn from patients. The program also strengthened her passion for end of life care decisions and she hopes to partner with other student groups to make this a broader part of the GIG mission this year. Julia is looking forward to this opportunity to collaborate with other students, faculty, and the patient community to continue to strengthen the GIG program this coming year.

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