Geisel School of Medicine at Dartmouth

Alumni Wisdom Book

STORIES OF MEANING, HEALING, AND COMPASSION

Volume II

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Geisel School of Medicine at Dartmouth
Alumni Wisdom Book: Stories of Meaning, Healing, and Compassion

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Congratulations on your Graduation Day and Welcome as Fellow Alumni!

We offer as a graduation present this book of medical wisdom stories written for you by alumni from of our Geisel School of Medicine at Dartmouth!

Today we welcome you, as colleagues, to the more than 6,000 fellow alumni of our medical school founded in 1797. We hope that these stories will provide a synergy of strengths and a source of joy and encouragement to you in the months and years ahead!

We felt humbled and honored to receive these stories from alumni and to work with the Alumni Engagement Office to put them into this book for you. We hope you will contribute your own stories in the future! We would like to continue this sharing of wisdom stories as a bookend to the White Coat Ceremony at the start of medical school.

May you find much personal and professional fulfillment in the decades ahead!

Sarah Johansen ’89/’90 • Joseph O’Donnell ’71 • Daniel Lucey ’81/’82

Dear Reader,

Phronesis is an Ancient Greek word for a type of wisdom or intelligence. More specifically, it's a type of wisdom relevant to practical action, implying both good judgement and excellence of character and habits, or practical virtue.

The Wisdom Book is a collection of stories and lessons submitted by alumni. To maintain the voice of each individual writer, editing has been limited to obvious grammatical corrections. As such, when you are enjoying the stories printed within these pages, please keep in mind that depending on when the alumnus or alumna graduated, terms such as DMS or Dartmouth Medical School were not edited to preserve the complete experience.

We hope you will contribute your wisdom stories to us via email at *Geisel.Alumni.Relations@dartmouth.edu*. Stories may be posted on our website at *www.geiselalumni.org/wisdombook* or printed in a future edition.

Sincerely,

Your Geisel Alumni Engagement Team

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Wisdom Stories

BY ALUMNI FROM 1955 TO 2022

Geisel School of Medicine at Dartmouth

Only Listen

BY JANE AUGER ’97

In 2017, JAMA published an article stating that a physician was only capable of listening to a patient’s initial interview for 18-23 seconds before interrupting. Try it. Set a timer for 20 seconds, start to read an article out loud, and see just how short that is.

You, as a medical student, are in the enviable (and never to be reproduced) position of being able to spend ample time with a patient.

Patients truly love to tell you about themselves, and not just about their medical problems. You’ll be able to find out so much more – their family life, fears, hopes, dreams. And, because you may feel that you don’t have any real answers for them at this point, you’ll be in the perfect place to listen. Listen to their words. Listen to the space between the words. Listen to the sighs, the tears, the anger.

Somewhere along the way, your patient will let you know what the real problem is. The patient has the answer.

As a 3rd year medical student, I had my short list of patients to follow. Among them was a Chinese lady who refused to eat. She was wasting away. Her doctors were considering placing a feeding tube because she didn’t want to die. Interpretation services were not as robust back then, and the translator didn’t speak her exact regional dialect.

One day, her daughter came in to visit as I was doing my daily exam. We sat down, and I told her about her mother’s reluctance to eat, and our fears that she was starving to death.

She began an animated conversation with her mother, then turned to me and said, “She hates the food here in the hospital.” I asked if she would eat if she had food she liked – “yes”. It was not easy, but we got permission for her family to bring in home cooked meals for her, and she ate with gusto. No tube required. Gained weight and got discharged.

I got to that place because I didn’t know the answer myself, but listened to someone who did.

So that’s my advice to you – take the time to only listen.

Thank You, Dr. Donald Wilson!

BY RUSSELL ANDREWS ’78

In 1974, I went directly from graduate school at Harvard to medical school at Dartmouth. My doctoral dissertation, on language organization in the brain, won the G. Milton Shy Award of the American Academy of Neurology. I had become captivated by the nervous system during graduate school and planned to specialize in neurology.

Dartmouth Medical School was renowned for having students be “hands on”. We took on (and were responsible for) the care of patients like the junior version of residents that we were. That “hands on” approach carried into the operating room as well.

During my first year at Dartmouth Medical School, a toddler was brought to the Emergency Department comatose after a head injury. This was before the CT era – one had to use the history and physical examination to make a diagnosis. Dr. Wilson determined the toddler was likely to have a hematoma, either subdural or epidural. I was fortunate to scrub in on this case – my first exposure to a neurosurgical procedure. The toddler had an epidural hematoma. Post-operatively, after the anesthesia had worn off, the toddler was awake, babbling, and soon made a full recovery.

That experience was life-changing both for the toddler and for me. Thanks to Dr. Wilson’s having me accompany him in the operating room, I began to realize that neurosurgery was a better fit for me than neurology. The next couple of summers were spent at the Department of Neurosurgery, University of Pennsylvania, learning about cerebral blood flow in the lab – but also again getting exposure to the neurosurgical operating room.

These experiences convinced me that combining basic research on the nervous system with the increasingly refined techniques of neurosurgery was the career for me. Twenty years later, while on the Neurosurgery faculty at Stanford, I edited a book entitled *Intraoperative Neuroprotection* – which captures the idea of neurology and neurosurgery working together to optimize patient outcomes. And more recently I have been fortunate to work with colleagues at NASA Ames Nanotechnology on nanoelectrodes to better understand electrochemical activity in the brain – so functional neurosurgery such as deep brain stimulation can actually correct disorders like refractory epilepsy.

Sadly, Dr. Wilson died of cancer in 1982 at the age of 55. His interest in epilepsy was not lost on me either. Hopefully our work on techniques to improve functional neurosurgery serves as tribute to Dr. Wilson. His life was cut short but his influence on me grows ever longer…

Thank you, Dr. Wilson!

Art's Advice

BY RICHARD BAKER, JR. '89

First of all, congratulations to all on your achievement! Job well done. From my perspective, having graduated from Geisel and staying on through residency and a few years on staff, you all have been fortunate to start your medical careers at Dartmouth. It is a truly special learning environment, filled with people who care. I am very grateful for my years in Hanover, Lebanon, and White River Junction.

As you embark on your careers, I'd like to share some wisdom from Dr. Arthur Naitove, one of my DMS mentors, later a colleague, and additional advice from another faculty member that took me a few years to fully appreciate. As you move into your residencies and beyond, you will possess a massive body of knowledge. You will have the tools to supplement that knowledge by accessing online data, up to date, and most of the medical literature from your iPhone. As I moved into practice, I was eager to share and apply this knowledge. I imagine most of you will be eager to do the same. Art once told me, "half of what you've learned from me and others will be irrelevant or will be proven inaccurate. Do your best to always be curious, to question, and always be a bit of a skeptic." His advice was spot on, and in that moment he conveyed years of his medical judgment to me. Over my years in practice in interventional radiology and neurointerventional radiology, I've come to appreciate Art's advice more and more. Over the last 30 years the field of interventional radiology has exploded with new devices, new minimally invasive procedures, new diagnostic imaging techniques and treatments. Much of this has advanced medicine, but not all of it.

Along similar lines, I remember when I was the chief radiology resident at DHMC. I was very proud of what I was doing and learning. I had a conversation with the Chair of Medicine at the time and was put off by his comments about a certain radiology test or procedure. I don't remember the specifics, but it had something to do with outcomes and outcomes research. As I look back on the conversation he was actually trying to teach me something similar to the lesson that Art had taught me. I was defensive and remember relaying this conversation to my chair. Later I learned that close to 25% of what we do as physicians is actually waste and does little to improve the outcomes that patients want. As an eager young physician it was hard for me in the moment to hear that a large part of what I had learned and was practicing, didn't matter and actually might lead to outcomes that patients do not want.

Maintain your curiosity, question, be open and stay up to date. Always look for the part of medicine that matters to patients and strive for outcomes that really matter to them. Sometime that could mean no test or treatment. You have to go slowly to speed up. You and your patients will be better off for it. Good Luck!

Put Your Patients' Needs First! It's a Win-Win.

BY STEVEN BARRETT '70

The practice of medicine is ever-changing and very challenging. Basic principles of care delivery have been upended by technology, economics, changing lifestyles of our patients, etc. So, as new practitioners of the art of medicine, we are pulled in many, often conflicting, directions in caring for our patients. Frustration and burnout are real.

Fortunately, there is one guiding principle for both individual doctors and medical organizations that can see us through and provide real professional satisfaction and, ultimately, improve the broken system. Very simply, it is: ALWAYS MAKE DECISIONS BASED ON WHAT IS RIGHT FOR YOUR PATIENT. It requires commitment to and practice of understanding and empathy for the person and family in your care. It requires laser focus to avoid all the other economic pressures and technological fascination that can get in the way of putting our patients first. But, in the end, our patients will appreciate that approach and it will always lead to the best outcomes medically, economically, and for personal satisfaction.

I learned this principle early on in my family medicine career. It served me very well as I started my own solo practice in the days of indemnity insurance, eventually merged with other family physicians to form a group practice to deal with the onslaught of managed care HMO's and capitated medicine, and eventually risk-sharing and value-based population medicine. It helped me make good decisions on all levels, both big and small, as exciting new technology and medicines joined the old tried and true methods and the demands and pace of practice intensified. That focus also helped me avoid economically self-serving decisions that did not add value for my patients.

Admittedly, as a self-employed physician, I had more control over the decisions I made than is possible in an employed model. But even I had to remember to push back against organizational rules of our accountable care organization when they did not serve my patients' interests. That is the state of medicine these days and it can be frustrating. No matter where you are, you must remember to advocate hard for what is right for your patients and stand firm. Physicians are still the backbone of the healthcare delivery system and we must regain our voice and power to make the system work better for our patients. That's what will preserve our sense of professional satisfaction and accomplishment in the end.

A Death Smile

BY SCOT BATEMAN ’94

I told Emily a joke every day I knew her
A dying child is still a kid
Who can and wants to smile

An 11 yr. old with relapsed T cell lymphoma
Bald, steroid chubby
Bedbound from weakness
Innocent and open
Loved and loving
Radiating hope
And trust in me, a second year resident

Admitted as a “last ditch”
Racking her body with one more round
Of energy sapping chemicals
Hoping

Day after day, I try to treat
Expected and unexpected complications
Learning as much as I can
About medicines and side effects
About central lines and infections
About tumor cells and growth

Emily knows and appreciates this
As much as every new joke
But the tumor ravages on
Nothing seems to be working
Her pain is real
She knows that I see this
The jokes are for her
“Why do Gorillas have big nostrils?”
Palpable anticipation of her laughing is fun
“Because they have big fingers”
Her laugh is hearty and genuine and infectious
But the jokes are for me too
She gets equal pleasure seeing me smile

It metastases to her spine.
Morphine drip becomes our main therapy
“It’s not good, is it?” she says through
knowing tears
“No, it’s not,” is all I can honestly say
She contemplates that answer
Suddenly, she asks
Curiously, earnestly, and fearfully
“Scot, what is it going to feel like when I die?”

My shock at her question
Induces a surreal state of mind
By stretching my preconceived notions
Of doctoring and caring beyond my boundaries
No one taught me how to answer that in
medical school

Words used particularly with kids
“You can fight,”
“Be strong,”
“Hold on.”
Come to mind
But they’re hollow
Her look demands honesty
We both know she is dying

I pause and ponder
The unknown and the unknowable
Hoping the words come out right

“I think you will probably feel like you are
falling deeper and deeper asleep,”
Says a slow, serious voice that quivers
“You will find it harder and harder to wake up
and see all of us here,
But finally you won’t be able to wake up.
Instead, you will be in your dreams from
then on.”

The words hang in the air
As she stares at me
With her own lie-detector

Her first words astound me
In their nobility and unfailing hope
“I like my dreams,” she finally says, resolutely
She starts crying uncontrollably
But I sense relief and a peace
Acceptance not fear
And I see just grace

My eyes have not been dry since her
initial question
They let loose as well
I marvel at the depth of my sorrow
That our medicines and best intentions
have failed
A child
But these tears calm me too
By finally being able to help this little girl
Somehow
Even if it was only hope in a dream

A few days later
Slipping in and out of consciousness
Emily starts saying goodbye
When she can
To family and friends who cared
One by one they leave her room
Shaking their head in disbelief
Wiping away tears

Later, alone with me in her room
Barely able to open her eyes
She wearily asks for a joke

As a joke
It is hard for us to smile

She motions for me to come closer
I lean in
“Scot,” she whispers
“You are going to be a great doctor.”

I look at her in utter amazement
Fumble for words of thanks
And feel so incredibly and deeply honored
By this beautiful gift
Yet, humbled beyond belief
Incredulous that her faith in me
Lasted longer than her body
My feeble definition of a good doctor
Altered and expanded forever

That is all she said
She drifted off into her dream world
And passed away that night, peacefully

A huge void existed the next day on rounds
One that was difficult
To fathom or interpret or describe
But in that emptiness
Was the beginning of a fullness
A spark of inspiration
That grows and grows
And blesses my life as a physician

Thinking of her now
Tears well up in my eyes
Such a tragic loss of a beautiful spirit
But ironically her memory
Enlivens each day with hope
Giving me the courage to smile

Can there be such a thing as a death smile?

Best Advice

BY ERIC DONNENFELD, ’80

The best advice I ever received about ophthalmology, and perhaps life, was given to me near the end of my second year of residency after I performed my first cataract surgery. I will always remember this seminal event. I would guess that many of us have an enduring recollection of our first surgery or procedure. I recall the patient, placing seven semi-radial sutures, and the absolute exhilaration of completing a successful extracapsular surgery including a posterior chamber IOL. The procedure had gone beautifully, and the patient’s vision had been restored. I had chosen my attending carefully, someone that I admired, trusted, and respected. As we walked out of the operating room together and removed our masks, I had a giddy grin on my face and he returned my smile and congratulated me saying, “Eric, remember the feeling you are experiencing right now. Every time you perform surgery in the future, remember this feeling and recognize what a privilege it is to be a cataract surgeon. Enjoy every surgery as much as you do this one. You have all the abilities to be a great ophthalmologist, but it is passion for our profession that separates the good from the great. If you do this, you will have a wonderful career.” Thank you Dr. Turtz. I have adhered to your advice, and I think about your words almost every day I am in the OR. In addition, I give this advice to every young ophthalmology resident or fellow that I take through their first procedure over the past 30 years.

We never stop learning in medicine. Ophthalmology is a vibrant specialty with constantly evolving challenges and new technology designed to meet and exceed the challenges we face. Digital online learning opportunities abound, transporting surgical teaching into our homes on a daily basis. Teaching today is becoming more interactive with audience response systems at meetings and video conferencing creating virtual encounters from our homes and offices. Despite these astonishing teaching advances, there is nothing quite as essential as the one-on-one training that occurs during residency between the student and the experienced surgeon. Teaching residents requires nerves of steel, dedication, and extraordinary patience. These surgeons are, in general, not compensated adequately in the traditional sense for their time and

effort but receive the inner satisfaction of performing a truly vital mission. Teaching is a gift and our colleagues who train residents are truly the unsung heroes of our medicine.

A Doctor's Watch

BY RICHARD EHLING '91

A Christmas gift, this congratulations
my mother's dream of Medicine
Rewards worn by
well intentioned men
Gold cased, emerald clasped
Two faced in a good way
a separate second hand
dialing heart beats back
when we wore watches this
alligator banded wealth broadcaster
Of course I smiled but soon
stated it destined for others
further up the ladder
So on Boxing Day
reboxed returned to
saleswoman at Tiffany
downcast, commission-less
as I eyed cased Diver's watch
a quarter the cost
but waterproof, thus blood proof
and tested to 300 aquatic feet

about the pressure I anticipated
rubber banded for easy cleaning
I announced its virtues
to crowd formed and soon
one became three
Her day measurably better
My first patient talked
through her depression

When You Cannot Forget, Remember with Purpose

BY JESSICA FRIED ’14

I still remember her face, the way her cold hand felt in mine, how small and frail she looked in the bed. I wish I could say that what I saw in her eyes was bravery and peace, but I cannot sugarcoat what I saw—fear and desperation. I spent more time in her room that last night than any patient before or since. We did everything we could, but it was not enough. She passed shortly before morning rounds. I excused myself to the restroom and wept for this woman who had become my patient only three days prior.

My attending in the ICU, notoriously steely and tough as nails, took me aside and asked me how I was processing the experience. I told her I felt like I had failed. Her advice to me was a salve that slowly healed my broken heart over time: sometimes, we do everything right, everything we can, and we still cannot save them. This is a hard reality of our profession that is balanced by the privilege of helping to give some of our patients more time to love and be loved.

She was the first patient who died under my care. I have accepted that I will never forget her, our time together, or her significance in my development as a physician.

Jack’s Crossing

BY JEFFREY GEORGIA ’81

While working as a radiologist in Helena some years back, I became a Montana fly fishing guide. As a volunteer with Project Healing Waters, I was guiding some Iraq and Afghanistan combat veterans on the Missouri River “trophy stretch” a dozen miles from my hospital. Having spent months caring for bent and broken humans aboard the Navy’s hospital ship “Comfort” off the coast of Iraq in the spring and summer of 2003, I discovered helping the Healing Waters people was providing them - and me - some solace from lasting effects of that experience.

Despite his quiet reserve, Jack, one of my two soldier clients, settled into the float and began to open up a little. He shared that while deployed, he was so greatly affected by the death of some of his buddies that he became obsessed with hunting the enemy with devastating lethal effect – even to doing this on his own down time, using “unconventional” equipment and methods. This led to his rapid discharge from the service for psychiatric reasons. It was clear he was still the grips of this trauma on joining the PHW trip, dealing with profound anger and grief, more than ten years later.

Jack had fished before, but was new at fly casting, and having difficulty “hitting the targets,” let alone hooking fish; he increasingly muscled the stiff, state-of-the-art boron/graphite rod that the Project had provided him. The harder he tried, the more his frustration grew, especially since the other Veteran in the drift boat had caught a couple of fine rainbows.

I sensed that a gentler, more connected (i.e. spiritual) approach might serve, so I unsheathed the ancient split bamboo rod my father had handed me in 1981, in recognition of my completion of Dartmouth Medical School (as it was then known). I told my developing skeptic that this was not a mere fishing rod, but a living, organic extension of the soul of the handler, and that it casted more slowly, and paradoxically guided with *less* effort. I tied on a minuscule midge dry fly and suggested

he get ready to cross it stealthily over to a circling eddy I knew, just beyond the approaching big rock, over by the far bank.

At first Jack objected - said that the rod “felt weird” and that he would never be able to “target the fly down range” as instructed, let alone hook a fish on that fragile stick and tiny floating spec of lint. However, after a couple of progressively slower practice casts, Great Spirit smiled, and Jack did perfectly shoot across and center the midge in the spot; we saw it instantly sipped under, and an epic connection ensued...

Twenty minutes – or a lifetime – later, having finally surrendered, the 23 inch rainbow (imagine a finned rugby ball), bearing battle scars of the ages, was producing agonal gasps in the bottom of the boat. The young fighter looked at me, smiling fiercely, and implored, “I can keep it?”

“The universe has given you a choice: you may kill it, or you may yet let it live,” I offered.

Jack’s predatory expression turned confused, then solemn... then crossed over into a kind of humble reverence. With astonishing kindness, he lifted his former prey over the side, and gently drew her fore and aft as we watched those waters infuse vitality into the former trophy... until, with an almost imperceptible tail flick, she vanished back into the depths’ shadows.

Truly, healing waters.

Meeting Death

BY KATHRYN GILL ’89

I recall my first medicine patient, an elderly Portuguese speaking man who spoke no English. As a 3rd year student, I was last in line to examine him. He was 68, fathered 3 children, had CA, pneumonia, and appeared to be suffering from pain. He also had the most remarkable presence– which struck me whenever I interacted with him.

On exam, I also thought he’d fractured his hip and kept begging my intern to get an x-ray. My intern kept denying the request, figuring my exam was incorrect. Two days later the x-ray was ordered and he received pain meds and more careful transfers in and out of bed. I grew very fond of this man.

One day at lunch, I felt a tug- no, actually, a summons. I dropped my utensils, said good bye to my classmates and ran up 6 flights of steps on the opposite end of the hospital, to his room. As the door swung open he turned to face me, smiled and held out his hand. I walked up to him, smiled and held his hand quietly and he died.

At first I was so shocked I didn’t know what to do. I called the operator and explained he was DNR and had just died; she said there was nothing to do. (I’m guessing I wasn’t the first student to call with this question in a moment of facing the unknown.)

A minute later… his family arrived. He gave me a gift - the gift of understanding, that Death can be met with Peace, the gift of knowing that, whomever is supposed to be there at that moment will be there... and no one else. And lastly, the gift of gratitude for my greatest teachers throughout a life time medical education, my patients.

To Live The Impossible Dream!

BY CLAIRE HASHIMOTO ’84

Having a Dartmouth Medical School education has had a profound influence in helping my loved ones. There have been several amazing miracles in my family, all stemming from having a Dartmouth Medical School education. After being on staff at Stanford in the early 1990’s, I began working in a privately owned esoteric testing laboratory in Phoenix. A decade later, my mother called me late Friday night, March 21, 2003 out of desperation for help, because my dad was diagnosed with central retinal veinous occlusion (CRVO) from extensive retinal hemorrhages due to hypertriglyceridemia. Dad had lost 70% of his vision. He was told by local physicians there was no cure and he would become blind soon. I immediately recalled meeting an exceptional ophthalmologist, Dr. Michael Gaynon, at Stanford where I was an investigator in molecular pathology. Miraculously, Dr. Gaynon returned my call late that night and said he was just starting a clinical trial on patients afflicted with CRVO and would schedule to see dad first thing the following Monday March 24, 2003. After an extensive workup, his diagnosis was confirmed and he was started on daily high dose niacin. After visits every three months for two years, his eyesight was completely restored!

Another wonderful miracle happened in 2015 when I retired and moved to take care of my folks. Dad had severe painful lumbar stenosis, refractory to steroid injections which were once effective. Having an intense interest in alternative medicine for the last two decades, I decided to perform acupressure on him. After only one session, he immediately was able to get up and take large steps without any pain! It’s been seven years, and he is still pain free!

I wish I had known what miracles a solid medical education can lead to when I was starting out. Although I have enjoyed my pathology career, helping loved ones has been the utmost satisfying, and made it absolutely worthwhile being in the medical field!

Do What is Right

BY EMILY JACOBSON ’15

Congratulations on your medical school graduation! As I reflect on life after graduating DMS, the most important advice I can think of as you begin your careers is to just do what you know to be right and to lean into and invest in relationships.

Your medical training has prepared you to be extraordinary doctors, public health leaders, ground-breaking researchers, or whatever else you desire to be. The early stage of your career will have moments of stress and self-doubt, though, and this is normal. You will have moments when you feel like you are being asked to do the impossible.

My first year as an attending hospitalist coincided with the start of the COVID-19 pandemic. Never had I, or the seasoned doctors I looked up to, felt so unprepared, overwhelmed, and scared. I vividly remember working overnight with Jimmy, my friend/co-resident/co-hospitalist, the first night our respiratory ICU opened up. In the midst of “controlled” chaos and decision-making with no good answers, we transferred over a patient from the main hospital with metastatic cancer with worsening respiratory status and overall decline.

Neither Jimmy nor I thought Ms. C had COVID but in the 1% chance we were wrong, it was on us for exposing the rest of the healthcare team. To make the decision to move her to our COVID ICU, though, meant she could have no visitors, including her son, an emergency room nurse in our own ED. Even when you are faced with impossible decisions, know there are always people you can rely on - make it an effort to foster and maintain relationships with your “people.” Neither Jimmy nor I would have made it through those first few nights without each other.

Ms. C continued to decline over the subsequent night. Through your training, you will have the heavy burden of being with people at the end of their life and come to recognize when your patient is dying. In honesty, I was dreading having to call Ms. C’s son to tell him this and to discuss the options of escalation of care. Patient after patient was decompensating, the pages were not stopping, and we were drowning. Remember, though, when you are in the same situation, what

you would want if it was your own mom, sibling, friend, and do what you know to be right. Make the call, have the conversation.

Ms. C ended up transitioning to comfort care and thankfully we were able to move her out of our COVID-19 unit so her family could be with her at the end of her life. I still see her son frequently and each time, he thanks me for caring for his mom. While both of us went through the same event from different sides, both of our memories carry heavy and different emotions. At the end of the day, don't shy away from the hard moments, hard decisions, or hard emotions — they are what will stick with you and truly matter to the people you have the privilege of caring for. Know that as you form relationships with your new colleagues, your DMS classmates and larger community of DMS alumni, will always answer your call. Go forth and do good.

Three Lives Changed Forever…

BY CALVIN JOHNSON '85

the summer heat was blistering…
it was my night to cover trauma anesthesia
the pandemic and George Floyd with
social uprising and sirens filled the air.

the tension was a thick cloud expanding
for blocks,
hovering over the trauma unit at Cedar Sinai.
good citizens in the wrong place,
at the wrong time,
victims of violence and chaos,
three lives changed forever…

he was thirty-three years old
risking his life "to protect and to serve."
dear officer "thank you for your service…"
each day you leave your family
to protect strangers from harm's way.
my utmost respect for our men in Blue…

the bottle crashed through his
police car window,
violently striking his head.
he loses consciousness,
blood was compressing his brain
requiring an emergency craniotomy.
I sprang into action and put him to sleep.

the skull was opened,
the blood was drained,
the surgery was completed,
but what was the verdict?

he opened his eyes,
he squeezed my hands,
he moved his legs,
he said his name,
he knew date, time, and place,
he was himself with no damage done.

he was twenty-five years young,
a light brown African American
an innocent victim of a stray bullet.
his lung, esophagus, and hepatic vein
all ruptured
the smell of blood filled my nostrils
I was gripped with fear that he would die.
my mind was racing as to what to do
I gave medications and blood transfusions.

I took a deep breath,
no, it can't be!
What's his name I shouted,
the nurse responded "trauma 999"

I was in a time warp,
my heart was pounding,
I could not think,
what would I tell his mom?
it would break her heart.

with a trembling hand
I pulled back the covers
to look at his face,
overwhelmed with relief
it was not my son…
and by the grace of God,
we saved his life.

the night was intense,
twelve hours of trauma,
my life changed forever…

Three lives changed forever…

These two acts of senseless violence occurred at Cedars Sinai Medical Center, Los Angeles, CA in the wake of the death of George Floyd. These events pierced my soul like a double edged sword. Entangled with the relief that my son was safe was the heartache I felt for these two innocent men and their families. I bowed my head and thanked God that good had triumphed over evil tonight.

Same Smile as She…

BY CALVIN JOHNSON '85

she flew into town
made a trip out west,
knee replacement surgery
was her request.

she and I in preop an excited look in her eye,
as I explained the anesthetic plan.
filled with happiness and joy she expressed to me
we have the same smile don't you see!

she went on to say filled with glee,
you have a smile I've only seen on TV
never in real life she continued to say
has a doctor with the same smile taken care of me.

she said the other smiles were not at all bad;
but a smile like mine was the first she had…
she beamed with pride
at the doctor's same smile,
and began the anesthesia journey with him at her side.

This is a poem case report of a 70 year old African American patient who underwent a total knee replacement. She had come to Cedars Sinai Medical Center in Los Angeles for her surgery during the pandemic. I am the African American anesthesiologist who took care of her. There has been an increased awareness, sensitivity and need for diversity in medicine in the USA during the

COVID-19 pandemic. This poem case report of my patient is not meant to imply that the physician must be the same race or culture as the patient in order to provide compassionate, outstanding care. Rather, quite the opposite. It is the diversity within the medical staff and department that brings awareness, insight, knowledge, compassion, and sensitivity to the entire healthcare team. As a result, the entire medical team develops closer professional relationships and friendships. This enhances the overall medical care provided to our patients.

Smart / Nice

BY JONATHAN KEEVE ’81

I left the pastoral bliss of DMS in June of 1981 and headed to Bellevue/NYU for a general surgery internship. Though I felt academically prepared, the clinical variety and intensity of a big city trauma center was a bit of an adjustment. There were protocols for GSW and SW to different body parts (gunshot wounds and stab wounds!) which were not common in the Upper Valley and a host of conditions I was expected to treat with no experience. I had never seen more really sick people in my life.

My first night in the SICU was a challenge. Managing IV meds, ventilators, many central lines and all manner of drains, wounds, and tubes was overwhelming. Rather than pretend I knew what I was doing (because I did not), I threw myself upon the mercy of the nurses. They were smart, capable, and efficient, and appreciated my humility and willingness to buy them coffee or even flowers on a birthday. Although there were still many challenges, I learned a great deal from them that served me well for years in residency and practice. I tried to learn from everyone and many of the most important things I did not learn from other physicians.

The most important thing I have learned in 35 years of orthopedic practice, medical mission work, hospital committees, group meetings, interviews, depositions and every interaction is actually very simple: **It is nice to be smart, but it is smarter to be nice.** Knowing every detail of a diagnosis or treatment may be helpful, but a kind, compassionate approach to patients, families and colleagues (including the nursing, OR and housekeeping staff.…) is vastly more important.

A Good Samaritan Story

BY REBEKAH KIM ’05

INCIDENT: JUNE 19, 2009

Penn Station, Long Island Rail Road, New York City

I was in my fourth year of surgical residency. By that stage, you would think I would have made up my mind and was content with my career choice of surgery, but still I was battling doubts. During operations, my mind was bombarded with insecurity and questions: “Why am I not more natural in the operating room? Why do I have to be 5 feet 2 inches? I wish I were 6 feet 2 inches like my attending. Then I would have more finesse with laparoscopic cases. Perhaps I am not cut out to be a surgeon.” These and many other regrets about my career choice preoccupied my thoughts.

I was completing my surgical residency in New York City, and I was on my way to San Francisco for a friend’s wedding. I decided to take the Long Island Rail Road (LIRR) from Penn Station to get to John F. Kennedy International Airport (JFK). I remember the morning vividly. I was post-call and had an awful night of trauma cases. I rushed out of my apartment and bought coffee from a corner kiosk. I remember asking for “milk with coffee.” The kiosk worker brusquely replied, “You mean coffee with milk.” It did not matter because I ended up spilling the coffee all over myself as I walked to the subway with my suitcase trailing behind me.

When I arrived at Penn Station, I bought the wrong ticket for the LIRR and ended up missing the train that I originally planned to take. When I finally got on a train, it was crammed with passengers. This was unusual, as it was past rush hour and going the opposite direction of the city. I asked the passenger next to me what was happening that morning, and she answered that it was the U.S. Open golf tournament.

That year, the U.S. Open was hit heavily with rain, resulting in multiple suspensions of play. I sat in my seat observing the golf shirts and hats on each of the passengers. People looked

sophisticated reading their *Wall Street Journal* or peach-colored *Financial Times*. I began to envy their lives. I thought to myself, “I wish I had time to go to sporting events. I wish I had more time and money, and then maybe I would not be taking public transportation to the airport. Look at me—I am a poor, overworked surgery resident.”

The train’s departure time had passed, and still the train had not moved. I asked another passenger what was going on, and was told there was a medical emergency and that the crew was asking whether there were any doctors on the train. I stood up thinking I should check out what was going on. After all, I thought, I am a doctor. There were police officers running to an adjacent car, so I made my way to the crowded car and saw the officers hovering over a man lying on the floor of the train car.

The man’s shirt was wide open, and a police officer was performing compressions. I made my way toward the head of the fallen passenger and said, “I am a doctor. What’s going on?” A wave of relief passed over the police officers’ faces as I uttered the words “I am a doctor.” I learned that the man had been feeling nauseous, and then fell to the ground, with no pulse. As I was gathering the history, I knelt above his head and performed a jaw thrust and asked whether there was a mask. To my relief, another police officer pulled out a portable Ambu bag. I held the mask firmly against the man’s mouth and told the officer to give a breath every five seconds.

The defibrillator pads were already across the man’s chest, and they had given one shock but the passenger remained pulseless. I coached the police officers to take turns performing compressions. I asked the man by the defibrillator machine to count down from two minutes from the last shock. He was counting down: “one minute … 30 seconds.” As he counted, I told the officers that I would check for a pulse at the end of two minutes, and if there was no pulse, they were to administer another shock. The police officer continued to count down: “10 seconds.”

I checked for a carotid pulse and there was none, so I instructed them to give a shock. The man’s chest thrust up from the ground from the shock, and then I ordered, “Continue compressions right away.” One of the officers chimed in, “Don’t we need to check for a pulse?”

“No,” I replied. “Continue compressions; count down from two minutes and I will check for a pulse then.”

We repeated the same routine. The officer by the defibrillator counted down: “one minute … 30 seconds … 10.” I felt for a carotid pulse and it was flat, and ordered, “Give another shock.” The officer near the defibrillator answered: “The machine says no shock indicated.”

Then, as if the fallen man had awoken from a deep sleep, his throat started to rattle with an inspiration as he gasped for air. The police officers cheered him on with fists in the air. “C’mon buddy, c’mon buddy!” I felt for a carotid, and at this time felt a bounding pulse underneath my two fingers. There were cheers among the police officers and the passengers standing around. I then said, “OK, no more compressions. Continue giving breaths, and let’s move him onto his side.” It was a moment of sheer bliss, to think that this man’s life was restored because of our efforts.

About a minute or so later, EMS arrived. They placed monitors on the man, and he was in normal sinus rhythm. I removed myself from the scene, and an officer approached me, saying, “Doc, can we get your name and contact number?” I hesitated but then gave him my cellphone number, and I went on my way to find the next train to JFK.

As I walked away from the scene, my perspective had been completely transformed. “Wow, everything went wrong this morning, but it was all meant to be.” No longer was I filled with self-pity, but instead thought, “What greater gift is there in life to have skills to save lives? I wouldn’t trade being a doctor for all the money in the world.” I knew that God had arranged all the sequence of events—buying the wrong ticket, missing my original train, so that I could be available to help this man and the police officers.

When I arrived in San Francisco, I received a call from the Penn Station police station. The officer informed me that the patient was taken to a New York City hospital and said in his New York accent, “The docs say that he’s gonna make it.” I replied, “I just want to congratulate each of the officers who helped. Because we worked as a team, that man is alive.” The officer replied, “Couldn’t have done it without you. You were the quarterback.”

Months later I received a letter in the mail on Jan. 2, 2010, from a law office. It read:

Date of Incident: June 19, 2009, 7:49 a.m.

Dear Dr. Kim:

I am the individual who was aided on June 19, 2009, on the LIRR. I have been in the process of tracking down the various individuals who assisted me, and of course your name has surfaced. I am happy to say that I have recovered substantially from the cardiac arrest I suffered and would very much appreciate the opportunity to speak directly with you.

I was in shock. Not only was the man alive, but he also had the mental capacity to write a letter. He was an attorney in New York, and I ended up meeting him and his family. We keep in touch through email and holiday cards. He has a slight weakness of his left side, but otherwise has done well after his cardiac arrest.

Looking back, I realize how difficult it was to keep perspective through surgical training. I am pretty sure I had deep depression during most of my residency, although I did not seek professional help. Unfortunately for some, surgical training results in despondency to a point where suicide seems to be the only option. I knew two fellow surgical residents who died by suicide during training, as well as an attending surgeon when I was a fellow. As surgeons, we tend to tell ourselves, “Suck it up. You can get through this,” and we do not address the deep hurt that we have inside. What we are called to endure is tremendously stressful—sometimes inhumane. There are no easy answers, but here are some suggestions to help you if you are at a point of depression:

1. Speak up. Do not keep your depression to yourself. Ask for help from a trusted colleague or peer. Ask someone outside your immediate circumstance for guidance. If you have family you can trust, talk to them about how you are feeling.
2. Take time off.
3. Quit your job—your patients will be taken care of. Your career is not worth your life, your marriage or your family.

We often miss the forest for the trees. You are not made to go through this alone. What we do, especially as surgeons, is significant, and we need all the help we can get. This incident helped me regain my passion for surgery and renewed my sense of calling to provide health care. It “resuscitated” me in a profound way—in a way that a code in the hospital would not have been able to. There is a beautiful irony in being a Good Samaritan—it does you as much good as it does to help others.

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Patients Memory- “Great Guys”

BY FRANKLIN LYNCH ’75

I hope to tell of an experience that taught me a heartwarming lesson about memory impairment that I learned because I listened and spoke with my patients.

I am Franklin Lynch Jr., Dartmouth ’72 and DMS ’75 and Dartmouth-Hitchcock Orthopaedics ’78-81. I was named after my father, Franklin Lynch, and called “Bud” as he was.

During my residency, my parents moved to Hanover and my father, a pediatrician, established a small practice out of his house across from the golf course on Lyme Road.

Franklin Lynch Sr. was born in 1915 and raised in Rowayton, CT, played football for and graduated from Dartmouth ’38, DMS ‘39-41, Columbia Med ‘41-43. He did 9 months of internship at Mary Hitchcock Hospital before assignment as a ship’s doctor on a Navy LST 282 participating in D-day off Omaha beach and the Operation Dragoon in Southern France 2 months later. It was there that his ship was hit by a German radio controlled rocket dropped from a plane. He was blown off the bridge, his battle station, and fell to the deck breaking his femur. The ship was laden with explosives that were going off below decks. He had been a great swimmer and lifeguard and chose to go into the water and pulled himself over the side and dropped into the water which had to be very painful. Evacuated to a tent hospital in Italy he was offered a “new approach” which was application of a plate to the femur. He was mobilized to the United States but he felt something shift getting off the plane. The plate broke because the fracture had not healed as the bone was infected at the operative site. He spent 4 years in hospitals, had multiple procedures and spent over 2 years in casts from his chest to toes before he could do his pediatric residency. He practiced Pediatrics in Westport CT 1950-1978. He had lost 4 inches of bone, had a very stiff knee and required a major lift in his R shoe walking with a limp. He was later diagnosed with a spine fracture that had stabilized with his prolonged rest. He did play golf, swam and skied and loved the opportunity coach his kids in sports while umpiring Little League games.

In his early eighties he had a fall at a family reunion and some pain started in his mid-thigh and he called me to see him and on exam there was mobility at the old fracture site with mild tenderness. X-ray demonstrated a lack of continuity at the fracture with mobility on stress x-rays. He also had a low grade fever and aspiration at the fracture demonstrated penicillin sensitive Staph Aureus. This demonstrated a phenomenon related to osteomyelitis where bacteria act like spores and lay dormant until activated by decreasing immunity of older age or new injury on top of the old. The “fibrous-union” at the old fracture site was debrided, drained and IV antibiotics applied for 4 weeks. With new aspiration negative, the fracture was debrided and an intramedullary rod applied with some bone grafting and progressive healing ensued over a 2 year period. A benefit was noted and his knee below the fracture was mobilized and bent better than it had since 1945.

Over the last 4 years of his life my father’s mental agility gradually deteriorated with loss of ability to drive due to memory loss. He became unable to be cared for at home and moved into the memory impaired unit at Wheelock terrace. He could no longer recall my name but was always enthused to see me or my siblings. He was always gracious to the staff and demonstrated the adage that “you catch more flies with sugar” and always treating people well will likely benefit you.

I was taking Orthopaedic call at DHMC in these years and I received a call about a patient in a memory impaired unit who had fallen and fractured his hip. I worried that this could have been my father based on age and fact that he was from a memory impaired unit. Fortunately it was in New London and was not my father. It was just evening and early surgery for hip fractures improved outcomes and so we chose a method of fixation and I met the patient outside the operating room to explain the plan and get consent. When I introduced myself as Bud Lynch he brightened and got a funny look on his face. He mused “Bud Lynch, Bud Lynch I knew a Bud Lynch once. He was a great guy.” When I spoke with his family we discovered that he and my father had been lifeguards together for a number of summers at a beach in Rowayton CT.

He did well and got back to his care facility within a few days. When I saw my father a week later he still did not know my name but when I told him I met an old friend named Frank DeCourville my dad said “I knew a Frank DeCourville once. He was a great guy,” The older memories were still there.

Be Open to Serendipity

BY JOHN MCGOWAN ’65

In mentoring students, it is common for me to hear “I am worried because I don’t yet have a 5-year plan” (or a 10-year plan, or a longer perspective). I tell them my story to help answer these worries.

I graduated from DMS in 1965 and finished up at Harvard Medical School (Dartmouth was a 2-year medical school then). I had no clear plans for my career when I was at Dartmouth, but rotations at the several Harvard hospitals convinced me that I wanted to care for the poor, so I applied for an internship at Boston City Hospital (BCH). When I matched, my 5-year plan was to finish residency and open a practice. My experience at BCH and a rotation in the cardiology center led to a new 5-year plan to become a cardiologist and open a practice where I could care for the poor.

I graduated during the Vietnam War, when the doctor draft took all medical school graduates. By serendipity, I became an Epidemic Intelligence Service officer at the CDC in Atlanta for a two-year stint. While there, I became interested in epidemiology and control of hospital-acquired infection, so my new 5-year plan now was to do a fellowship where I could test the recommended actions for infection control, and work at a hospital that cared for the poor. I went back to the BCH as a fellow in Infectious Diseases to pursue my new 5-year plan.

At BCH, my mentor was Dr. Maxwell Finland, a world authority on antibiotic use and antibiotic resistance. Doing research with him was so interesting that my new 5-year plan was to become an academic seeing patients and doing research on antibiotic resistance and control of hospital-acquired infections.

By serendipity, at the time that my fellowship ended, hospitals were starting to be required to implement an infection control program. This allowed my new 5-year plan to become an academic who worked at a university with a hospital that cared for the poor, and do research on antimicrobial resistance. I accepted a position with Emory University and Grady Memorial Hospital, the hospital that cares for the poor of Atlanta.

By serendipity, 25-years after I began working at Grady, Emory University started a new School of Public Health (SPH). Because of my background, I was asked to teach and do research there. My new 5-year plan was to move to the SPH and teach epidemiology (because of my CDC background) and do research on antimicrobial resistance. After 22 years at the SPH, my new plan was to retire, and I did.

The point of all this is that serendipity will likely provide many opportunities for you to use your medical skills in different ways. If you rigidly adhere to one plan, you will miss these great ways to spend your medical life. Be open to the circumstances that come up, and don’t worry about changing course when you see benefit. Serendipity will be your friend during your career, and you rarely will be doing the same thing throughout. Look forward to this!

Empathy Skills

BY RICHARD MORSE ’87

As a pediatric neurologist, I do a lot of consultations in the intensive care nursery. Parents naturally want to know what the future holds for their infant; sometimes it helps them make difficult decisions about redirecting care. A pregnancy ends when a baby is born, and this time is laden with emotion and stress, especially when something goes wrong. Parents are bombarded with multiple caregivers, mountains of information, high stress, lack of sleep, and emotional strain. It is a shock to see their baby in an isolette, with tubes coming out of every limb and the umbilicus, a ventilator hissing, nurses hovering, screens buzzing and blinking, frequent alarms raising the tension in the room. The environment itself is overwhelming.

I am often called in for family meetings when a baby has had a hypoxic-ischemic brain injury. These are difficult conversations, often a delicate balance between fact and fiction. When I first started in my career, I prided myself on giving as objective an account as I could. I tried to put feelings aside. However, as I followed these families over time and saw the high rate of divorce and the effects of disrupted bonding in many, an important aspect of my role as advocate for my patient emerged. I kept a wider, more complex picture in mind during family meetings. The baby’s needs are better met if the parents can bond with each other and feel supported as they cope with the overwhelming experience they are going through. It takes careful listening and encouragement to help them articulate their questions and voice their fears, all while grieving the loss of their expectations. I learned that having better-adjusted parents makes a major difference in the child’s life. I realized that careful listening, empathy, and humility about the limitations of our ability to predict outcomes were more important than data. I have found that hope is an important factor in a family’s recovery from trauma, and that not everything needs to be said in the early days. Life itself unfolds over time, it is a process.

Experience is the best teacher. You grow into being a doctor, are shaped by the experiences, grow by embracing the hardest encounters and overcoming your fears.

Despite all the preparation, and despite all the knowledge, it is more important to be present to the moment when you are with the patient (or family).

Empathy, active listening, cultural humility, and professionalism. These are the most important clinical skills that make for effective clinicians.

How This Physician Escaped the System

BY NITHYA NATRAJAN ’13

“Wrong! The most important part of your job is to make money.” I will never forget those words from an attending in residency – though I did not know it at the time, it was a pivotal moment in my decision to pursue a nontraditional route in medicine. I loved my patients; I loved the critical thinking required for taking care of them, I loved the scientific knowledge underlying the care we provide as physicians. However, making money would never be the most important part of any job for me. The most important parts of my job would always be caring for my patients and providing for my family (the answer that my attending found so offensive).

It was not until complications following our first baby’s birth that I allowed myself to look for a way out of this system that was so at odds with my own values as a physician. I still vividly remember rushing back to our OB’s office at 4:45 pm actively hemorrhaging for the second time just days after our baby was born. My hemoglobin came back under 6 in the office where they also saw possible retained placenta on ultrasound. My heart rate was somewhere in the 140s and my blood pressures were in the 70s/40s when I got to the pre-op area a few minutes later. The anesthesiologist asked for two large-bore IVs and quickly started talking about other options to give fluids and blood because they were having trouble finding veins. Somewhere in there I began to panic because I knew what the vital signs meant, I knew what trying (and repeatedly failing) to place IVs meant – it meant I was in hemorrhagic shock and may not make it back to my baby and family. My dad called our family from the pre-op area. I tried to calm down and told my husband not to worry – I told him our parents would help him take care of the baby. It was the single most terrifying moment of my life, but it also taught me that there is no point wasting your time doing something you are miserable doing.

It took time to process the trauma of what happened. It took time to figure out what I wanted to do. However, I quickly realized going back to traditional patient care was never going to be an option. I started working locums 1 day a week at a private practice, began doing chart review work for Medicaid part-time, and still had plenty of time for our family. After our second baby was born, I decided to drop the locums work and focus on my nonclinical work – adding utilization review to the functional capacity assessments I was already doing. I enjoyed the work and it paid adequately for our needs, but it still felt like something was missing.

I missed caring for patients, but knew that I could not go back to an insurance-based, high volume practice. After having our children and a difficult time with breastfeeding with our first due to our delivery complications, I found a love of learning about breastfeeding, infant nutrition, and how to help other new parents. After helping friends and family who were having difficulty feeding their new babies over a few years, I spent the first 6 months of the pandemic completing the certified lactation counselor (CLC) course and continuing medical education (CME) on breastfeeding medicine. During that time, I also worked on the logistics of setting up a cash-based breastfeeding telemedicine practice which launched at the end of 2020. The plan is to eventually expand this to a more comprehensive direct primary care (DPC) practice with a brick-and-mortar location once our children are older. The Female Physician Entrepreneur group and resources about how to set up a DPC were both extremely helpful in figuring out the logistics of how to bring my vision to life.

Burn out, moral injury, whatever you want to call it – what the system is doing to compassionate, thoughtful individuals who followed a path in the hopes of caring for others is absolutely wrong. For me, the problem was never about caring for patients – I enjoyed helping them figure out what was going on, managing their medical problems, and helping them make difficult decisions. The system was the problem – endless charting, spending hours learning how to follow rules that had nothing to do with patient care, taking additional time to fill out stacks of unnecessary paperwork, the list goes on. By refocusing on the doctor-patient relationship with a direct care model, it finally feels like I can get back to practicing medicine and taking care of patients in a meaningful way.

If you are happy with where you are in the current system – that is wonderful, continue what you are doing. However, if you are feeling trapped, frustrated, or like the work you are doing is no longer meaningful, then there are plenty of opportunities for you to get out of the system. Start looking at your options – start learning about them and looking for opportunities now. Whether

you end up deciding on an alternative clinical career, a nonclinical career within medicine, or a career outside of medicine altogether – you have the skills you need to succeed as long as you are persistent. There are options if you want to stay employed and opportunities to start your own business. The critical thinking skills, listening skills, and drive to succeed that you need to survive training to become a physician can help you create a career that will support you and your family and allow you to live a fulfilling life. The first step is to start.

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Acceptance and Bad News

BY JULIA NEILY ’04

I was nervous. I always got nervous administering blood because I knew if I made a mistake, I could kill the patient. As I went to hang the blood, I read his name and date of birth. I had to compare the information on the oak tag of the blood to the carbon copy paper listing name and month, day, year: 1962. I looked up and before I could think I said,

“We’re the same age.”

Phillip lay in the bed; his short blond hair was messy with sweat. The room was dark, he didn’t like the lights on. His eyes were half closed. His lips were chapped and crusted with blood. We had tried Vaseline, but it didn’t help.

What did he say in response? I can’t remember. But we locked eyes for a moment, silent.

He was dying and I was vibrant and alive, it wasn’t fair. I felt guilty to be hanging the blood instead of in the bed. I had my whole life ahead of me, I was a nurse, he was in a bed soon to die. When he died, I hated it. Why was I healthy and able to worry about hanging blood correctly and here was a man in his twenties like me soon to die?

This was in the mid 1980’s when AIDS first came out; there was no cure, only treatments. I worked on the oncology unit. Another patient down the hall also had AIDS. His father was a reverend, and he thought his son got AIDS as a punishment from God for being gay. I disagreed.

But Phillip got AIDS from a blood transfusion. Whether the patient was gay or not shouldn’t have mattered, but I sensed judgement from others, like when a patient came in through the ER drunk with grime caked under his fingernails that hadn’t been clipped in weeks.

It didn’t matter how my patient got AIDS. Since Phillip got his from a blood transfusion there was a feeling of he’s okay. As for the gay man down the hall, I sensed an undercurrent of judgement from others. We weren’t supposed to judge but I could feel it.

I wish I had known that it was okay to get to know my patients as people behind the disease or ailment for which they were being treated. I was taught that to be professional I'd keep my distance. But that's not me and I couldn't help connecting. Now I know that as long as my boundaries were professional it was okay and good to connect with my patients.

Speed ahead twenty years and I was the mother of a patient. My middle baby, at the time, was a year old. After many tests they told me, there's something wrong with your baby's brain. I'm sure they said it more scientifically, but I was shocked. Here was my beautiful red-headed angel and there was something wrong with her brain. Her brain waves were slow and therefore her thinking and cognition was slow. No idea what the future would hold for her. Would she ever talk or hold a job or have friends?

The doctor left and I asked for the priest to come. He entered the room, looking around as if to say, "who died?"

"I'm sorry to bother you, I'm sure you have other patients who might be near death, but there's something wrong with my baby's brain," I said and I started to cry. This was a broken dream that I couldn't imagine. The priest sat.

"Doctors are very smart, but they don't know everything, only God knows everything," he said.

I don't remember much else after that, but I've carried those words with me in the years since. We thought my daughter might never talk but now at 16 years old she is in a school for kids with special needs. She has friends and volunteers at a day care. The future is open.

I wish I had known when I first started my career in healthcare how important it is to find what each patient and family finds comforting when getting bad news. For me it was spiritual support, for someone else it might be a friend or loved one nearby holding their hand. For others it might be to write in a journal or text a friend.

The importance of acceptance is one of the greatest lessons I learned and wished I'd known earlier. I would have accepted that it was okay and even made my work richer when I got to know my patients better. I also would have accepted that each patient and his/her family coped differently, and I would have offered various forms of support rather than just my listening ear.

Practical Advice

BY OGOCHUKWU OKPALA '02

Congratulations on your graduation! Good luck with residency.

This is a very proud moment.

Please be very aware that the Medical Board in each state grants you the "right" to practice medicine and that right can be taken away by them, too. It may seem so easy now. You (hopefully) have nothing in your background so licenses are issued easily. But it can be taken away by things we all do every day.

Did you know that divulging information about yourself to a patient can be a boundary violation? No? I didn't either. It takes away from the primacy of the patient-doctor relationship and puts the focus on you as a professional.

You can lose your license by not doing your CMEs or not finishing records in a timely manner. Once you do, it goes in a national databank and it's something you have to report in every application you make to a hospital. You can be excluded from insurances too and it's a long, painful, expensive pathway to getting your license back.

I recently came before the board of my state and was shocked at how much they were NOT on my side. Their only interest is to protect the patient and the community. You have NO say. Do not do home visits, unless that's the normal course of your business. Document, document, document, even the shortest phone call. Get in the habit of telling people to make an appointment at your office – this means nurses, fellow doctors, and friends. Lawyers never give you free advice over the phone.

Read the particulars of your state board to know what they allow and disallow. Some things are obvious, others are not.

So, sorry to be depressing, but this could literally save your career.

Now that you know, you have no excuse not to do well!

Good luck out there!!

Don’t Worry, be Happy

BY NICK PERENCEVICH ’70

In the fall of 1988 the song “Don’t Worry, Be Happy” by Bobbie McFerrin was #1 in the pop music charts. Its soothing reggae beat reflected a laid back attitude that I was trying to adopt. I was moving my family (3 kids under 10) to a new job in New Hampshire. I had been in a private practice for 8 years working out of two community hospitals just outside Boston where issues around my ability to deliver responsible patient care were becoming worse, particularly around nurse staffing. I realized I was only as good as the help around me. I was unhappy and worried about my patients, my practice, my family and myself.

A decade earlier I was completing my surgical training. As the last part of more than two generations of Dartmouth Medical School students who all finished medical school away from Hanover, I had done my last two medical school years as well as my residency in Boston. During that training there were two quotes literally written on the library walls where I often studied. One said “The secret of the care of the patient is caring for the patient” (Dr. Francis Peabody 1925) and other said “The fundamental act of medical care is assumption of responsibility” (Dr. Francis Moore 1961). I tried to follow these messages and found that a total focus on the patient’s welfare was a way to spend less time thinking of myself. When “off call” I tried, often unsuccessfully, to focus on my wife, family and friends. Self-introspection didn’t exist. I was too busy thinking about the patients. Even though I worried a lot about them, I was still pretty happy.

A few years before the “song” came out there was a lawsuit filed in NYC about a college student named Libby Zion who died under the care of sleep deprived and under-supervised residents. The suit eventually led to a law passed in New York State in 1991 restricting resident working hours which then led to similar national residency work hour regulations in 2003. In Boston, I got to know Dr. Leslie Ottinger who ran the surgical residency program at Mass General for almost 40 years. He retired in his 70’s in 2003, and said as he was transitioning from care giver to himself a patient “in truth, tired and knowledgeable is considerably more to the patient’s advantage than

rested and ignorant." He suggested to his successors that if MGH was going to follow the new regulations, they would need to extend the training period by several years. Surgical programs throughout the U.S. were affected the most by the new work hour restrictions. The goal was to improve patient safety by reducing errors and improve the health and well-being of all residents.

Since 2003, with the continued work hour rules, several observations have been made. In surgery the national board exams showed a lowering of scores and a higher percentage of failures. The goal of training knowledgeable, skilled, competent and safe surgeons however needed to continue. This led to modifying the work hours some and also the development of further training years with more fellowships taken by residents completing general surgery. What no one was able to prove with less hours working was that less errors happened (i.e. patients were safer) and that surgeons in training were happier even though they were allegedly more rested. After 2003 burnout became a more talked about topic in all fields of medicine. To me burnout happens when one is spending a lot of time worrying about oneself, and less time focusing on one's responsibility in caring for ones patients. The joy of medicine is when you (and your team) take total responsibility for the care of your patents when their lives most depend on your caring. That act of your selflessness is very rewarding even if the outcome is not.

My advice to new residents is that when you start your on-call night don't go to your call room worrying about whether you'll get lots of calls and lose sleep. Before bedding down go through your patient list and worry about what the next bad thing that might happen to each patient and continue working to make changes in care that will prevent problems before they happen. Sounds pessimistic, but it really isn't because you're worrying about the patient and making changes to help them….otherwise you're being afraid of the patient and worrying about yourself. You want to be afraid FOR the patient and NOT OF the patient. Even though you might get less sleep doing this, remember you're doing good work and you'll sleep better and be happier when you go off call. Now when I hear that Bobbie McFerrin song I think… don't worry about yourself but be happy worrying about others, especially your patients.

Even though the work is hard, there is much joy in the immersion of oneself in taking on the responsibility of care. Remember that what we do as clinicians is important and patients really know if you care about them or not. Don't hold back on working on their behalf with the knowledge and skill that you process. Have a low threshold in seeking help from your peers, staff and your supervising attendings. Focus on listening and learning. When patients say thank you remember they really mean it and that thank you is your reward and antidote to burnout. This type of thinking has helped me in over 40 years of clinical care. Maybe it can help you.

Learned Humility

BY BRADLEY PICKETT '85

The path in medicine after medical school requires humility.

At the end of my internship in the military, I was assigned to a medical clinic in central Germany. With only one year of surgical training after medical school, I was anxious about being a primary care provider for a large infantry division and their families in a foreign rural community. I learned, day-by-day, how to treat both mundane and not so mundane health problems in a young adult population, but before I was able to start feeling comfortable in my new role, my commander volunteered me to cover the emergency room at a medical center in southern Germany. With yet another opportunity to step out of my comfort zone, I was relieved to learn that I would have other, more experienced physicians alongside me during my day shifts. I learned later, however, that I would not enjoy such companionship during night shifts. In fact, at night, not only was I the only doctor in the emergency room, I was the only doctor in the hospital.

One night during a solo emergency room shift, I was called urgently to the ICU to assess a patient with acute intra-abdominal bleeding. She was in shock and the nurses were unable to get venous access while they waited for her surgeon to arrive. I knew that the patient needed a saphenous vein cutdown and it didn't look like I had time to wait for the surgeon. I had, actually, never done a cutdown on a human … but I did one on a pig cadaver in my ATLS course. I quickly gathered my supplies, inject the skin around the ankle, made an incision and began searching for the vein. During my frantic search for the saphenous vein, the surgeon arrived and quickly inserted a central line. While resuscitating the patient, the surgeon thanked me for my enthusiastic response to the ICU emergency. Then he leaned over and whispered to me, "The saphenous vein is on the medial side of the ankle, not lateral."

As physicians, we are all fortunate to have opportunities to humiliate ourselves, especially early on during our medical careers. Accept that you will have those experiences. Learn from those experiences. Become a better physician because of those experiences.

Observing Observations

BY MATTHEW PUTNAM ’77

From the first patient you treat without a “co-pilot” to your last, you will make choices that reflect on your own and your mentor’s love of medicine’s tools. Experience garnered from failure and success, inclines me toward the support of patients, less toward the treatment. Testing to be certain of a diagnosis often takes less training, less skill, less compassion than being a thoughtful observer. Many medical textbooks are full of treatment algorithms that communicate certainty of action where none exists. Alexander Cope’s *“Diagnosis of the Acute Abdomen”* and Mercer Rang’s original *“Children’s Fractures”* are two exceptions worth reading, regardless of your chosen area of focused study. If you have never taken the time to listen non-stop to *Beethoven’s 9th Symphony*, or the 30 minutes to read and read again, *Shakespeare’s Sonnet 116*, or the time needed to read St. Crispin’s Day speech in *Henry 5th, Act 4, scene 3*, find the time. The value of these things is that they are timeless touchstones to the careful purpose of work in an endeavor that carries purpose and responsibility beyond any monies you will earn. If these touchstones of mine are not yours, no matter. Find your own that inspires “purpose above self” and let them carry you forward on one of the noblest journeys a human can make — acting to benefit others before yourself.

The Train Ride

BY STANLEY ROSENBERG ’55

It was the fall of 1954. I was in my last year at Dartmouth. I was completing their “six years in five” program. The previous year had been considered my senior year in college and my first year of medical school. This year was my second year of medical school. This arrangement saves you one year.

The place is gorgeous; a wonderful picture. The trees were in the last of their fall foliage. You have to see New England to believe how beautiful it is in the autumn. Thanksgiving was approaching. I decided to cut class and leave campus a day early, to spend the Thanksgiving holiday with my family in New York.

I was on the old “Boston and Maine” railroad. About an hour south of Hanover, the train suddenly lurched to a stop. A few minutes later, a frantic conductor came running through the car. “Is there a doctor on the train? Is there a doctor on the train?” A few minutes later, he came running up the aisle again. “Is there a doctor on the train?”

This time, I stood up. “I’m only a second-year medical student,” I said. He grabbed me by the arm. “You’re all we’ve got.” He took me outside to a scene of carnage that I shall remember all the years of my life. It was a “grade crossing,” a place where the unprotected road intersects with the train tracks. There was no physical barrier. It was a rural area, long before automated gates became common for at-grade crossings.

The train had struck an old pickup truck. The force of that impact had tossed that pickup truck and its occupants many feet away. There had been a family of four people in the old pickup. The mother and father were dead. Their little girl was also dead. She had been thrown through the air and her head had struck a tree.

The fourth person, a little boy, was still alive. He had landed on a patch of grass. He was unconscious and foaming blood at his mouth, barely clinging to life. As I was examining him, what passes for an ambulance in this impoverished rural Vermont community came up. It was an old hearse and their “stretcher” was a sheet of plywood.

Four men came over and started to forcefully try to get the little boy onto the plywood board. I stopped them. “Listen,” I said. “He has a punctured lung. If you move him slowly and carefully and drive slowly and carefully, and try to keep him as still as possible, he will have a better chance at survival.”

Just about then, another old pickup truck drove up. The driver approached; he turned out to be the brother of the deceased man. Anguish! Pure anguish! It was a kind of anguish I had never seen before. The man paced back and forth, repeatedly striking his fist into his hand. I took him aside and spoke to him briefly. “You have been given a duty. You must raise that little boy as if he were your own.” Eventually, information was exchanged and the train got back underway.

I don’t remember much about the rest of that Thanksgiving vacation.

Back in class at Dartmouth one morning the next week, I was summoned to the Dean’s office. “Rosenberg! What were you doing on that train?” Busted!

“Dean Savage, I cut classes and left campus a day early. How did you know I was on that train?”

“It was in the papers. They gave you credit for saving that little boy’s life.”

Silence.

“I believe you were meant to be on that train. You’re excused.”

Stunned, I went back to class.

So my Jewish mother was right: “Be a doctor, you’ll always make a living and you might do some good.”

Bet On Yourself

BY KAOCHOY SAECHAO ’00

Somewhere ages and ages hence, I hope you will be telling your story with a sigh. You had the courage to bet on yourself and took the road less traveled by.

When I was at Dartmouth, I recall we were a small group of non-traditional students. And I assume that tradition has continued. There was an accomplished modern dancer among us who had an affinity for his roommate’s beer. There were also a few Olympic medalists, a Top Gun fighter pilot, a few serious bagpipers (and more than a few not-so-serious harmonica players), a rocket scientist, a nuclear submarine officer, and a few wild cards. Such is Dartmouth, and you have to love the place for it.

The intellectual arc of a physician begins with medical school and continues on into residency and, ultimately, into adulthood. As time progresses, with its attendant victories and unkind blows, the dust settles and we all fall into our designated slots in life. We all eventually gravitate back to our DNA, just in a more contemporary version of those before us - but preordained nonetheless by our genes.

So, I challenge you to be the wild cards.

Live a life of the liberal arts and enjoy being a human being. Befriend painters, quilters, ceramicists; buy their work and support them. Go for that oxtail soup in the Jamaican restaurant. Eat with your hands in that Ethiopian restaurant you drive by all the time so that when asked at an Ethiopian wedding which reception room you’d like to go into, you can pick the room with awaze tibs and zilzil tibs instead of the one with baked salmon. Go all-in with the bull jumping ceremony part of the wedding. While surrounding the couple in the middle of the room, you will jump rhythmically, arm in arm with your new-found friends. You will throw sweat on one another. You will scream and chant the newlywed couple to the moon. You will get all the words wrong.

You will laugh harder than you ever will. And you will love every second of it. Bask in the glory of the lived human experience. It will make you a better doctor.

With raw talent, luck and connections - all at your disposal at Dartmouth, my advice to you is to always bet on yourself. Start your own practice. Start your own company. It will be the most important decision you will make in your career. Starting your own company is hard; harder still is the decision to bet on yourself. You will remove yourself from a life of comfort. Explanations will have to be given to your mother and those close to you. You will have daily setbacks; things will never work out as planned; 1+1 will not always = 2. Life's expectations will not be linear. Trajectories will zig zag in random order. Yes, blood, sweat and tears. All that. It will also rob you of a big part of your soul. That's just the reality of starting something worthwhile. But if you've always wanted to bet on yourself and are foolish and courageous enough to do so, I whole-heartedly recommend you take a deep breath, close your eyes, and GO FOR IT!

I did. And that has made all the difference.

A Father's Eyes

BY STEPHEN SCHULTZ '92

It is internship. Autumn. Shorter days, longer nights. I am doing pediatrics. It is 3:30 AM. I am answering a page to talk with parents on the infant floor. I have not yet been to bed, and my eyes have begun to burn. I want to lie down. I want to sleep. I enter the room. A young woman with long frizzy red hair sits just inside the door, facing away from me. She is rocking in a rocker, in short, clipped strokes that seem odd, almost frenetic. A man is sleeping on a cot, turned away from me. He is wearing Birkenstocks; the soles face me.

"Excuse me..." I trail off softly. It has been more than half an hour since I was called. I hope the question has answered itself. She looks up. I see now she's holding a baby.

"I'm Dr. Schultz, the resident on call. Did you need to see me?"

"Oh, yes, Doctor. I'm glad you're here. I thought Daniel was looking a little bit more swollen, but I think he's better now. He's starting to breast-feed a little bit again, see there?"

I look down at a floppy, grotesquely swollen infant, perhaps 6 weeks old. He has a tube coming out of one nostril, and an IV in one hand. A nipple is being brushed across his lips as his mother persistently guides her breast to his mouth, but he is not making any movement at all. His eyes are swollen shut. My God, this kid looks bad. I am suddenly, painfully aware that in my haste to get to sleep, I have neglected to check the chart, or even to locate the name on the sign-out sheet to find out the principal diagnosis. What an idiot. A slow sensation of mild panic begins, similar to when I have to introduce someone whose name I should definitely know but cannot remember. This woman continues to talk, almost to herself. I am suddenly reminded of a crazy woman in King of Hearts, clutching a blanket she thinks is her baby. This kid is as interactive as a blanket.

Suddenly I know. This is the infant presented at morning report two days ago. Had a low-grade temp for two days, then spiked high. They took him to their doctor the third day, after he became lethargic. An LP was done. Sheets of polys, sheets of gram-positive cocci. Decreasing mental status. Transferred here. CT scan showed cerebral edema. NG tube placed secondary to inability to feed. Difficulty with fluid balance. Grim prognosis, unlikely to recover neurologically. Toasted squash.

"What do you think, Doctor?" I look down. Mom is looking up at me. I don't know what the question is. What am I doing here?

"What happened?" I turn around. Dad has woken up and is sitting on the edge of the bed. His hair is rumpled. He is hunched forward, his arms straight down at his sides, his hands clutching the sides of the cot.

I don't understand. "What?"

He straightens, looks up, and our eyes lock. "What happened?" he repeats softly, but more clearly.

I only have to look into those eyes for a second to know what he is asking. I realize he's not asking what happened to make this doctor come into this room at this hour. Three days later this man is still trying to sort out what happened to his son, what happened to the baby he already loved more fiercely than he thought it was possible to love. Will he live? Will he breast-feed again? Will he walk? Will he ever laugh with me? Oh, Sweet Jesus, please, what has happened to my son?

He looks away, and shakes his head. "I don't understand," he mumbles.

I stand in the center of the room. I don't know what to say, and very quickly I am unable to say anything. It is all I can do to suppress the ball of grief that is growing in my chest. Images of my own son fill my mind: the toothless grins and sweet breast-milk breath as a baby, the squeals of laughter of a mischievous toddler, the warmth of his sleeping body nestled in my protecting arms, the innocent questions that challenge me, make me pause, make me smile. The tricycle rides, the snowball fights, the ice cream cones, the love. And through it all, the fierce desire to protect him, to allow him to explore, but to shelter him from all harm. The love.

The rocker squeaks faintly, rhythmically.

Grief rises into my throat. "I... excuse me," is all I can say, and before I can even get out the door the tears start. I walk quickly past the nurses' station, and the sobs begin, like a vomiting spell that can be suppressed only so long, and once started cannot be controlled. A runner from transport walks by, staring. I duck into an unlit conference room, lean against the wall, and surrender to it, purge myself. It is the discordance of those father's eyes and the cynicism of "toasted squash," of sleep deprivation, of the insecurity of internship, of the fears of my own son's mortality. I cry for a long time.

My beeper goes off. I wipe my face, blow my nose. I don't go back into the room, and I don't leave a note.

I never see them again.

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My Lessons

BY DEBORAH SHURE ’71

Wisdom is not so easy to come by. As we go through life, professionally and personally, we have many moments of significance that generate narratives that warm us, warn us, sustain us, or sadden us. We learn with our minds and hearts open to the world. Every story is personal. You will have your own.

At the risk of sounding like a simplified self-help book, I would like to share a few things I have mostly learned from friends and colleagues wiser than me. All reinforced by experience. So here are some things to consider:

- Everything takes longer than you think it should. Be patient with yourself and others
- Try not be make career decisions based on how long the training will take. The time will pass whether you are moving toward your goal or not. You might as well be aiming for something you want.
- If you feel intimidated or self-conscious, remember that most things are not about you. They are about the subject, the other person, the issues. In making your case, remove “how am I doing?” from the table and focus on “what do I need to say or do to achieve the goal.”
- Sometimes it is about you. When it is, try to remember that you are of value too and plan actions accordingly, without fear.
- It can be hard to know what we ourselves are thinking and even harder to know what someone else is thinking. Being less judgmental and more open to inquiry can usually help everyone involved. Conflict resolution is part of life. Honest openness can help.
- Life should be enjoyed and as joyous as possible. Try to be open to the glories as you deal with the noise.

Revel in your stories!

Reflective and Resilient

BY CHARLES THAYER ’79

During the last days of my NYU Surgical Residency, I was urgently called to the Bellevue Hospital Emergency Room. This wasn’t unusual, in fact, this sort of thing happened several times a day. It was my privilege to be the Chief Resident for Trauma. As Trauma Chief, I was also Chief Resident for New York City’s prison system. As such, I had the opportunity to meet some of the country’s most notorious convicts. I strived to treat them as any patient, with respect and to the best of my ability.

What was unusual, as our team arrived, we weren’t greeted by the latest NYC disaster but by the mayor and an official delegation. Mayor Koch read a proclamation thanking me for my service to the City of New York and handed me a sizable check. I was shocked and found it difficult to compose myself. Standing before our team of nurses, residents; students plus representatives of EMS, Fire and Police it was most humbling and a singular moment in my medical career.

This story isn’t complete without reflecting on an earlier incident. As a 2nd year resident, I was shepherding a group of “pre-ops” for next day surgery. One was a “triple-A” repair. In those days, this warranted a stay in the ICU, with lots of “lining up”. During the night the patient had an episode of tachycardia. It resolved. The nursing staff was concerned. I fell asleep and forgot the issue. The next day the patient died from an intra-op heart attack. Through the years I have reconciled that I was not the sole cause of the patient’s death. At the time I felt different. I thought I was finished, at the end of my career. Of course, my career was not over, and I went on to earn a coveted position.

Only upon requests to recall special moments do I remember NYC’s proclamation, but I often think of that death and the lessons it taught me.

Last week a colleague, a younger orthopedist, had an elective case with an intra-op death. He came to me looking for support. He had not slept since the incident. He is gifted and I predict, in time, he will be celebrated.

In residency you will never be the sole cause of the suboptimal outcome you lose sleep over, but each will be an opportunity for reflection and resilience. Be certain, we are all humbled in our craft.

5 Life Lessons for the Working Clinician

BY CINDY TSAI ’14

Did you take any time off during your medical training? Perhaps to give yourself a break and reflect on the meaning of life?

I went straight through mine. Even though I would see and hear about others taking breaks, I never thought I needed it. I was 100% focused on becoming a doctor ever since I was young. Every completed year of school and training was a milestone marking my way to the light at the end of the tunnel. And every milestone I passed made it that much harder for me to give up. I was terrified to start over. There are times, however, when I wonder how different things would have looked had I taken time off. Would I have given up on medicine to pursue a different career instead?

Despite a rewarding career as a primary care physician, I have long felt like something was missing, and that I was here to do more. In my frenzy, I realized I missed some important lessons that, thankfully, I have learned since. I hope my experiences provide some insight and perspective to other clinicians, whether you are still entrenched in medical training or living life as an attending (new or seasoned).

First, more money does not lead to safety or security. My sense of safety and security came from within, from personal reflection on my situation and circumstances. At first, I was so excited to finally get a “real” paycheck, but soon thereafter, I realized I was still worried about many things. You can feel content on a meager PGY salary or feel like you are lacking even after making six figures. Do not select a specialty based on the amount of money you expect to make. You will be a hamster on a wheel, chasing endlessly and being forced into golden handcuffs. Focus on what you love instead. Your “why” will keep you going, especially when things get rough.

Second, pain is critical and not something to fear. Being an optimist, I always wanted things to be positive and view the glass as half full. I was afraid of pain and failure because of how I thought it would make me feel. However, I have since learned that pain is simply an alert or notification to pay attention to. Think about when you touch a hot stove and feel pain. The pain notifies you that something can be potentially harmful, and so you withdraw immediately. You don't keep your hand on the stove for hours to feel more pain. As soon as you notice and acknowledge the pain, you can process and release it. "Difficult" emotions only linger when we don't allow ourselves to feel them, which intensifies and makes them worse. When you are unafraid to feel any feeling, positive or negative, you will be all in and live a truly extraordinary life.

Third, "there" is not necessarily better than "here." We like to think the grass is always greener, but it's often not the case. I know residency and overnight shifts aren't easy. When I was feeling stuck as a primary care physician, I thought leaving work was the perfect solution. But I didn't want to run away as an escape. I learned how to love my job and was so grateful to serve as a physician for many years. And then I made the decision to leave later on because I wanted to.

Do you rush to change your circumstances — hospital policies, your work hours, people you work with — so you can feel better about something? When you are continuously replaying your past or worrying about the future, you are not living in the present. But the present is all you have. It's when life is actually happening. In order to enjoy life, you have to actually show up, be aware of the here and now.

Fourth, patient satisfaction surveys, attendings, and administration cannot make you feel inferior. It's your interpretation of their behaviors that makes you feel a certain way. I remember getting pimped so hard as a third-year student that I was bawling and bitter for days. Remember that we cannot control others. Life happens, and it's messy. Other people will always have their own reactions, just like you have yours. If you notice yourself getting upset and triggered by something, pause and acknowledge it. Get curious about it. It is a wonderful opportunity for self-understanding, because triggers are simply messages or signals that something similar has happened in the past, and they direct you to the areas that need more healing and love. It takes courage to look within, but if you don't heal the wounds, the hurt will only keep coming back, louder and louder. Learn to practice self-compassion and be your own best friend. Trust that it's possible to heal and work through the past. You are stronger and better because of, not in spite of, your past.

Fifth, you are completely worthy, enough, and amazing as you are. Yes, even as a med student on the first day of your ward rotations, because you are a living, breathing human being. You are not more or less valuable because of the letters behind your name. We are all born worthy. You

do not have to prove anything to anyone. Sure, it is gratifying to serve as a physician, but true validation comes from within. Know that even without a medical degree or long white coat, you are enough. Medical training (and clinical practice in a pandemic especially) can be demoralizing. Please don't forget that your worth is completely dependent on you. When you believe and trust yourself, you have your own back and know that you can handle anything that comes your way. There is nothing to prove.

Through mindfulness practices, I have learned to be present without judgment and to recognize that I have full responsibility and control over how I feel, even if something unexpected happens. This means there are no problems, only opportunities and solutions. May you live with ease throughout it all.

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A Good Story

BY JON WHITE ’80

This publication is intended as a collection of stories and I do have a story to tell. It’s not an anecdote or a single incident but it is a good one and, in my mind, it’s the most important story of my life. It started when I graduated from DMS in 1980 and continued for the next forty years as I worked as an academic surgeon and, more importantly, as a physician. I retired last year and now have some free time to reflect on my professional life and plan the rest of the story.

I grew up in the 60s and 70s and was drawn to the notion that a career in medicine was a chance to do something good for the community, which was in synch with the vibe at the time. Being from the middle class, I was also trying to advance beyond my parents’ working-class origins. It was their version of the American Dream, which eventually became mine. They had sacrificed for me and now I had to sacrifice some of my time and effort to give them a payback on their investment. When I weighed the pros and cons, it seemed like medicine was for me. Like most people, I have made my share of bad decisions in life but becoming a doctor was not one of them. I am now completing the arc of my professional career and find it has been much better than I could have hoped for and, like many doctors, I am very proud of my professional body of work.

Now that I am retired, I find that my greatest challenge is to find something that comes even close to the satisfaction, usefulness, and yes, pure joy, of being a physician. I still do voluntary teaching at two medical schools in town so I still see students virtually on a somewhat regular basis. Although my topics are usually physiology-related, I have the impulse to interrupt each lecture to tell the class what a great profession they have chosen and explain exactly why that is. I used to lecture in small conference rooms where I could see the audience and could tell that there were some in the classroom who felt the way I had forty years earlier and were probably weighing the same issues. To those students, I know you will not be disappointed and are in for a lifetime of sometimes exhilarating, sometimes depressing but always challenging professional encounters. There will be triumphs as well as personal doubts, but in the end it will all be worth it. With Zoom I can’t see your faces, but I know you are out there. I know there is a still whole legion of students that have the same hopes and questions that I had years ago and to them I would say you are just starting on the most incredible journey. Eventually, it will be your story to tell and I hope we get back to the conference rooms soon so I can see you again before I write the coda to mine.

Remember

BY WILLIAM-BERNARD REID-VARLEY ’15

When the human that’s come to seek healing
Becomes just gender and age—
And notice of a new admission
Just another monotonous page—
When vital cadence becomes just a rhythm
And a heartbeat no more than heart sound—
Remember the thrill that surged through you
When the life-giving pulse you first found.

When your name is o’erburdened with titles
And your brow bears the wisdom of years—
When your footsteps are heavy with knowing
And you are the first of your peers—
When you have become the lore-master
And your wish is now others’ command—
Forget not the fear and the trembling
When you first offered assessment and plan.

When you’re no more perturbed by the passing
Of a soul emplaced in your care—
When you mark it no deeper nor longer
Than a chill in the cool autumn air—
When the final exhale of departing
You note simply as agonal breath—
Remember the undying hour
You first were entrusted with death.

When you throw the long coat o’er your shoulders
With no more thought than a cloak in the rain—
When its meaning has faded with memory
And wearing it becomes just mundane—
When reverence to routine surrenders
As years beyond number do flow—
Remember the weight of the white coat
When you stood on that stage long ago.

The Only Patient I Truly Ever Saved in my Career

BY HARVEY WOEHLCK ’85

At an institution that I won’t name, I was once assigned to do an organ harvest on a patient that had been declared brain dead via an apnea test. In their defense, the state of the art for declaration of brain death was rather primitive in the 1980’s. As I was young and gullible in those days, and as I about to wheel the patient to the OR, his snarky and singularly unpleasant ICU nurse told me to wait until she gave the scheduled dose of pancuronium. And she didn’t say that very nicely, IMO. To make sense of the flow of this story, you have to know that I also have a very sarcastic side to my personality, and it’s easily triggered as a response to perceived social injustice or being managed by individuals who don’t understand the situation that they’re in charge of. I think even Joe O’Donnell himself has seen this side of me. So, I pretended to be the tail wagging obedient puppy and asked politely when the drug was to be given and why the patient needed it. After all, I certainly wouldn’t want the patient to miss a dose of such an important drug in his last few minutes of life! The thoughts running through my head were that if I give enough rope to an idiot they will eventually hang themselves. She said that without it, she couldn’t suction the patient because he coughed too much. I’m sure she thought that she was educating me, a mere novice at the game. After a short pause, I said, in my best Graz accent, **“I’ll be back.”** I’m not kidding – I actually said that. The “Terminator” movie had recently come out and was quite popular, so it was a bit of an inside joke on my part, presuming the nurse wouldn’t know. As a result, I got reinforcements with more seniority, and we reviewed the chart and the medication administration record and determined that the patient failed the apnea test because he was totally paralyzed with pancuronium. An arcane system for transcribing physician orders had resulted in the actual medications to be administered from a 3x5 card (maybe it was 4x6) that was updated with all the new orders but did not have old orders taken off in timely fashion. His initial paralysis orders were never canceled IRL when the order was canceled in the order book. Clearly this was long before electronic medical records existed. I then thought I’d get the afternoon off. So did I get out of doing a case? Nooooo! Just as I was starting to relax, I was notified that I now had to take the patient to the OR (after somebody had an embarrassing informed consent discussion with the family, I’m sure) for a much longer operation to fix femoral and other fractures. Eventually, the patient walked out of the hospital under his own power. Nobody ever said thank you for discovering the patient was alive and trapped in a paralyzed body, about to become an organ donor. Although I’ve been in practice for over 30 years, and after all that drama, I never even remembered the name of the only patient that I ever “saved”. But, that part has never mattered to me. I’ve thought about that moment when I could have just gone ahead without actually questioning. Like so many people say, just keep your head down and do your job. And I’ve never regretted the fight.

The Role of Chance in a Lifetime of Medical Research

BY PETER WRIGHT ’65

It all began when I applied to one college, Dartmouth. I was accepted and during my junior year applied to Dartmouth Medical School. By this time I was deeply committed to my future and present wife, Penny, and to the idea that I wanted to do research. After completing medical school at Harvard and starting my training in Pediatrics, it seemed logical to consider time at NIH particularly as the other option might be time in Vietnam. What a rich experience that proved to be and to this day I build on knowledge and approaches to the scientific method that I learned there. Importantly, I was exposed to the power of vaccines as a source of good and impact on human health. As I was completing by clinical ID fellowship in Boston, an option arose for me to spend time at the Hôpital Albert Schweitzer in rural Haiti. Again a fortuitous chance that led to over 40 trips to Haiti and close ties with Les Centres GHESKIO in Port au Prince. Fast forward to busy career in research and clinical ID at Vanderbilt interrupted by a call as to whether I would like to spend a year with the Expanded Programme on Immunization at WHO. I came home with this option and Penny and our kids said, “When do we pack?”

Finally, the option arose to return to roots in New England and to Geisel. Again we have found a rich environment and valued colleagues and now I have to face the last choice I will make of leaving medicine and becoming, as long as I can handle them, a sheep farmer and steward of our land in Norwich. Lessons learned 1) always pick up the phone, 2) treasure your colleagues and family, 3) be prepared to take risks and, 4) above all, be curious about the world around you.

“In the fields of observation, chance only favors the mind which is prepared,” wrote Louis Pasteur, to which I would add “Chance favors those willing to take risks” and Robert Frost wrote “Two roads diverged in a wood and I-I took the road less traveled and that has made all the difference.” Finally, maybe Yogi Berra said it best, “When you come to a fork in the road, take it”.

Look at This When You’re Having a Bad Day

BY MARTHA WU ’97

In 2014 I decided to leave the medical practice where I had been for 14 years to join a different primary care setting. Doing so meant that many of my patients would no longer be continuing their medical care with me. The last few months of patient visits and saying goodbye to patients were very emotional. During that time, I received many cards, letters, and emails from my patients thanking me for my diligent and compassionate care over the years. I don’t know what possessed me to save them, but I decided to print the emails and together with the letters and cards, I put them in a folder that I titled “Look at this when you’re having a bad day”.

And I’m so glad I did. Because as much as practicing medicine is gratifying and fulfilling, there are times when it is also extremely difficult. The stakes are high, and occasionally there are bad outcomes no matter what we do and how hard we try, and whether we did everything right...or didn’t do everything right. Sometimes patients are angry. Even when it is seemingly unwarranted, it is upsetting. Reading words of gratitude and praise help to remind us how much good we do, and how much it is appreciated.

There may be times when you aren’t having a “bad day” per se, but you may be feeling overwhelmed and stressed, feeling as if there are too many patients to see and too much work to do. This folder helps during these times too, as a reminder of why we went into medicine in the first place.

Heather

BY OGE YOUNG ’75

She was only 15 years-old. Her parents brought her to the emergency room wrapped in a blanket when she came downstairs, her blue jeans soaked with blood. Still bleeding, the ER nurses removed her clothing and dressed her in a hospital gown, placing a sheet over her as she laid shivering on the exam table. Taking care, I placed her legs in stirrups and recognized her immediately.

What seemed like only a few years before, Heather had played on a 3rd and 4th grade basketball team I coached. Her bright hazel eyes, long dark hair and quiet demeanor were unmistakable. She was tall and slender, athletic, but not aggressive, making plays without bringing attention to herself.

In sixth grade, Heather was in class when I discussed fertility, pregnancy, labor and birth, even miscarriage and contraception. The “talk” had become a spring ritual for the sixth graders moving onto middle school. I suspect, a little embarrassed to know me, she avoided eye contact and asked no questions that day.

Now, she was my patient, a young woman, lying frightened in front of me. Holding her mom’s hand, a gentle exam revealed a uterus 12-14 weeks size. Late first trimester miscarriages were frequently fraught with severe hemorrhage. Inserting a small speculum, I cleared the vagina of large clots and clumps of tissue, and then grasped her cervix with an Allis clamp. I carefully placed a large suction curette into the uterine cavity through a well-dilated cervix. With suction, her uterus emptied of residual tissue and blood and her heavy bleeding stopped abruptly, as the uterus contracted around the curette.

Then slowly, I removed the instruments and placed her legs back on the table. I explained that she had been pregnant and that she had experienced heavy bleeding during a miscarriage. That her miscarriage was over now and she would no longer have painful cramps. Her bleeding would only be scant.

I made clear that there was nothing she had done, or not done, to cause the miscarriage, that miscarriage was very common. That miscarriage occurs by chance whenever a pregnancy is abnormal. That someday, if she wanted to have a baby, she should be able to have a normal pregnancy. All the time, I wondered if she recognized me.

Looking away she continued to hold her mom’s hand and asked if she could see her father. I met him in the waiting room and described briefly what had happened. He appeared bewildered and sad, but grateful that his young daughter would be fine. Bringing him to her room, I watched the three of them huddle and hug tightly.

I followed Heather’s life at a distance through her high school years. We never talked. On occasion, I would see her parents who would greet me graciously, but we never discussed that night in the emergency room. Heather was an outstanding student. She received many awards for her achievements, always blushing with the recognition. Eventually, she graduated from college becoming an elementary school teacher. She married a young man who was a teacher as well.

To my surprise one day, they presented to my office pregnant. On exam her uterus was 10 weeks size, consistent with her menstrual dates. Together, we heard a fetal heart, assurance that she was carrying a normal pregnancy. Remarkably, she remembered that fact from my sixth grade lecture. As I helped her sit up, I congratulated them. Heather smiled, like I had never seen her smile before. With the glow of pregnancy, she said, “Thanks coach.”

Waspam

BY OGE YOUNG ’75

The ten-passenger Cessna bounced its front wheel along a cow path in an open field of Waspam, a village on the northern Atlantic Coast of Nicaragua. We were a medical team, led by a retired general surgeon, who had rebuilt the local hospital after it burned to the ground during the Contra-Sandinista War. Villagers, anticipating our arrival, ran to greet us, a few of them pushing wooden wheel barrows to carry our supplies.

Two nurses, wearing white uniforms and their caps, asked to meet the obstetrician. I introduced myself. Their Miskito language was foreign to all of us, but we deciphered that they urgently wanted me to see a laboring woman. Jumping into the back bed of a rusted pick up, missing several of its body parts, a short ride delivered me to the hospital. There, I met Maria, a young woman who had been fully dilated and apparently pushing for many hours.

Exhausted with blood shot eyes, she no longer mounted enough strength to push effectively with her contractions. An exam confirmed that she was completely dilated with a markedly edematous presenting part stuck in her pelvis. I suspected it was the baby’s head deflexed, with a brow or face coming down. Amazingly, there was still a heartbeat. With the help of an interpreter, I explained that we would give her anesthesia to relieve her pain, and then perform a C-section to deliver her baby.

Maria would not let go of my forearm, until she understood those words. We summoned the nurse anesthetist and moved our patient to an old operating table in another room. She received several liters of IV fluid as she was prepped and draped. General anesthesia was induced and a C-section performed. Remarkably, the baby cried after bagging her briefly.

The lower segment of the uterus was paper thin (almost ruptured). With vigorous massage, an injection of Pitocin directly into the myometrium and 40 units of IV Pitocin pouring in, the uterus finally contracted, averting a severe postpartum hemorrhage. A markedly molded face and brow appeared deformed initially, but within 24 hours the baby girl, named Mary Celcia, became “the most beautiful baby in the world.”

Our group from New England had flown to Managua the night before. Two young women general surgery residents from Managua’s medical school traveled with us to Waspam. They hoped to learn some obstetrical and gynecologic surgery. Residencies are rare in Nicaragua. Only 5 percent of graduating medical students are able to train in a specialty like surgery. Selection is highly competitive. Most graduates are assigned a year of internship in a rural community and often stay to practice for years.

Resources and access to health care are limited. One of the surgical resident’s mother died of cervical cancer at 54. Few Pap smears are done and treatment of premalignant (dysplasia) and malignant cervical disease is rare. Cervical cancer is one of the leading causes of death of Nicaraguan women. In contrast, cervical cancer now ranks 14th as a cause of cancer deaths in the U.S. The HPV vaccine will have a dramatic effect on incidence of cervical cancer in developing countries.

During my stay in Waspam, women and children traveled days on foot to visit our clinic. Several times women with complicated labors arrived by stretcher from outlying areas transported by women from their villages. Large fibroid tumors of the uterus were endemic in this population.

Many women anemic from heavy menstrual flow required hysterectomies. The surgical residents were pleased to learn good operative techniques.

One dramatic case we witnessed was non-surgical. A 10 year-old boy presented with a severe periorbital cellulitis. He was crying in pain, with fever, having red, tender soft tissue surrounding his right eye, leaving it swollen shut. The next morning, after only two doses of penicillin, the boy greeted us smiling, playing with his carved wooden truck on the front porch of the hospital. He had no evidence of residual infection. I suspect the staph and streptococcal bacteria of Waspam had rarely seen antibiotics!

The area was beautiful, a lush rain forest on the Coco River dividing Nicaragua and Honduras. Houses were built on stilts because of flooding. It was hot and humid, but temporary relief came during intermittent heavy rainstorms. I frequented a swimming hole in a brook near the hospital to cool off between surgery cases. Nights were uncomfortable, sleeping on sheets under mosquito

netting. No cold showers were to be had as the water was collected off the hot tin roof of our bunkhouse.

In two weeks, we accomplished what felt like a lot, but regretted that we could not do more. My last case was a mini-lap tubal ligation, a present for our scrub nurse. Medical trips have always reminded me of why I chose medicine. To experience the lives of these Miskito natives, so poor by our standards, but so rich in happiness, changes one's perspective on life.

I returned home, still feeling Maria's grip on my wrist, elated that we could help her, but keenly aware that many young women in parts of our world continue to risk their lives giving birth. It is startling that obstructed labor is still a leading cause of maternal death in developing countries. Wouldn't it be wonderful if a large portion of our military budget fed, housed and provided heath care for others, even our adversaries? Perhaps we would have no wars.

Life is a Journey

BY DOUGLAS ZIPES '62

As the only son—I have an older and a younger sister—I received a lot of attention growing up. My becoming a doctor was the family's dream to gain standing in the community and respect from relatives and friends. Since I liked biology and science, problem solving, and helping people, it was my dream as well, and the decision was a no-brainer. Medicine was perfect. I would become a doctor.

The high school guidance counselor had other ideas. When I asked her for advice about the path to medicine, she said, "No, you can't." The unstated reason was that I was from a modest, working-class family. In her judgment, blue-collar kids didn't become doctors.

"And that's *if* you get accepted into a good college—a big if," she added. She was sure there'd be no scholarship and my grades would suffer from having to support myself with afterschool jobs. No way would I finish college, never mind medical school. "Why waste your time? Just work with your father in his auto garage. That's the best thing for you."

I did help my father at "The Place" during winter weekends when I wasn't caddying. The garage had no official name because it was little more than a big room filled with auto equipment. I learned how to replace shock absorbers, brake pads, align and balance wheels, and set spark plug timing.

I knew being a mechanic wasn't my thing, even before I almost killed myself twice at The Place.

The first time, I was backing a car off an elevated ramp after changing the brake pads. I didn't realize someone had moved one of the two parallel metal tracks leading from the floor to the ramp. As I backed the car, I suddenly heard my father yell, "Doug, stop!" I jammed on the brakes just in time. The right rear wheel was suspended over ten feet of empty space and the car was teetering, about to roll onto its side. I got enough traction on the left tire to drive back onto the ramp. But it was close.

The second time was when I was changing shock absorbers. My father had gone to get a new set from an auto supply shop, and I thought I'd surprise him by having the car ready by the time he returned. I had the automatic wrench whirring off the old bolts on the right front shock when I heard my father once again shout, "Doug, stop!" He had just returned and saw I had forgotten to put a jack under the shock before taking it off. The shock absorber was a few threads away from springing loose and jackknifing into my face.

As if these incidents weren't enough to convince me I would never follow in my father's footsteps, another event, seared forever in my brain, did.

It was 1954, Christmas vacation when I was fifteen. I was home writing a book report on Conrad's *Heart of Darkness* (a boring read at the time that was homework over Christmas) when my mother called from her secretarial office at the *Reader's Digest*. Westchester County was in the middle of a blizzard and many *Digest* editors' cars were stuck in the parking lot. Would I help my father put chains on their cars? We could make five bucks a car.

It wasn't a question, not if I wanted dinner that night. I donned parka and boots and trudged four blocks to The Place. The temperature was an icy fifteen degrees, with biting, gusting winds blowing snow into six-foot drifts. The pewter sky forecast a tenacious storm. Auto traffic had all but stopped, and the streets were empty. By the time I arrived at The Place, my eyebrows were frozen, and I couldn't feel my nose, ears, or fingertips.

Putting chains on a car is a daunting task in ugly weather with a foot of snow on the ground and fingers stiff with cold. It took us almost half an hour working together to wrap spiked chains on the rear wheels of our family Buick. Despite the freezing temperature, we were drenched in sweat and covered in snow.

Finally finished, we drove two miles at about twenty miles an hour from Pleasantville to the *Reader's Digest* in Chappaqua, the next town over. The road was a whiteout, peppered by dark clusters of cars that had skidded into the ditch alongside.

My mother met us at the entrance to the *Reader's Digest* main building, a three-story red brick edifice with a tall, white central spire that made it look like a church. She guided us to the editorial office. The warmth of the brightly lit interior hallway started to thaw my frozen bones.

We paused at the doorway to a large room, and I gazed out at the editorial staff sitting at their desks, typing away. At least a dozen men and women, all warm and dry, were dressed immaculately in jackets and ties, white shirts, blouses, and skirts.

My father and I stood awkwardly at the threshold, dripping in grimy overalls, muddy boots, and black knit caps pulled low over our ears. We were going to slog into that blizzard for five bucks a car while the editors remained warm and cozy. It was a surreal moment.

I was overcome with embarrassment and shame. I know I shouldn't have felt that way. After all, we were just a hardworking father and son ready to provide a service and make an honest dollar. But that was how I felt. I looked at them, and I looked at us, and I silently vowed, *never will this ever happen to me again. The fires of hell won't prevent me from becoming a doctor. I will not be an automobile mechanic.*

We all have different motivating forces that propel us to accomplish many things in life. And we all suffer setbacks during our journey. Life is like that. However, several things ring true. First is how you handle adversity. Getting back up after you've been knocked down separates winners from losers, those who continue to do battle from those who quit. Second is the realization that life is a long journey, a marathon not a sprint, and it's the journey that is important, not artificial goals set up along the way. And above all, to never forget that family is paramount. In the final analysis, your parents, your spouse, and your children are more important than the sum of all your accomplishments. What you achieve will make them proud, but never replace their love and support.

Extracted from Damn the Naysayers. A Doctor's Memoir. Published by *iUniverse* 2018

Stick To Your Principles

BY DOUGLAS ZIPES ’62

In 1983, while consulting for Medtronic, I came up with the idea of delivering an electric shock over a catheter in the heart to terminate a rapid heartbeat. We called it the synchronous intravenous cardioverter. I am listed as the sole inventor in the U.S. patent, but Medtronic is the assignee, and all proceeds have gone to them. I’ve never received a penny— my wife has reminded me many times that, while I might be a smart doctor, I’m a lousy businessman.

Medtronic built the device for me to test and then fabricated the PCD, a pacemaker, cardioverter, and defibrillator combined into one electronic unit that incorporated my invention.

Around this time (late 1980s), I gave a lecture during which I said the PCD was the Rolls Royce of devices. A salesman for Eli Lilly, which sold their own version of the defibrillator via their company, Cardiac Pacemakers Inc. (CPI), took affront, reported what I’d said to his superiors, and triggered a maelstrom of legal controversy.

The CPI defibrillator was still under patent protection. Lilly sued Medtronic, claiming that Medtronic was “preselling” its PCD device and, in so doing, infringing on Lilly’s patent protection. Judge John William Ditter of the United States District Court in Philadelphia decided in Lilly’s favor and, in 1988, ordered Medtronic to cease its activities.

Since much of my own research at the time dealt with the cardioverter I had invented and the PCD that evolved from that invention, I refused to stop lecturing, publishing, and researching in this area. Lilly complained to Judge Ditter that I was violating the court’s order. The court found Medtronic in contempt and ordered them to tell me to stop immediately.

Medtronic did so, but I refused.

Medtronic explained to the judge that I was a consultant, not an employee, and they could not control my actions. Judge Ditter instructed Medtronic that he would control me through them.

He ordered Medtronic to fire me as a consultant immediately, to pay me no money either owed or in the future, to remove me as the principal investigator of the intravenous cardioverter and PCD study, to confiscate all related material and devices from my office, to sever all communications with me, and to make a public announcement of his order. Medtronic had no choice but to comply.

To say I was devastated would be an understatement. I was crushed to be so vilified publicly for defending what I thought was my right to work and lecture as I chose. I was not a party to the lawsuit between these two behemoths and had done nothing wrong—except to be caught in the middle.

I had to fight back tears when the Medtronic representative, accompanied by a law enforcement officer, came into my hospital office to remove all educational material—some of which I had written— about the transvenous cardioverter and PCD.

The next months of legal agony and ostracism were horrific. My reputation and integrity were more important to me than any worldly acquisitions or accomplishments, and I was devastated. I was forced to justify my actions to the dean of the medical school to avoid university reprimand, and to hire a lawyer to defend my First Amendment rights.

Added to the stress was that, at the time, I was president of the North American Society of Pacing and Electrophysiology (NASPE, now called the Heart Rhythm Society), the largest group of heart rhythm experts in the world. Leading this important society when all its members knew their president was in legal difficulties was a challenge.

Judge Ditter’s court order began to unravel because one of the patients in the transvenous cardioverter study was a federal judge. When he heard I could no longer take care of him, he called Judge Ditter and insisted I remain his doctor. Judge Ditter relented. Then, when other patients heard about this exception, they also demanded that I remain their doctor. Finally, when a device malfunctioned and no one could reprogram it correctly, I took over and—defying the court’s contempt order to have no patient contact whatsoever—fixed the malfunction and saved the patient.

Medtronic appealed the court's decision. Almost a year after it all started, the US Court of Appeals for the Third District heard the case and reversed Judge Ditter's decision, ruling that Medtronic's actions did not infringe on the patent. I was vindicated and welcomed back to Medtronic with open arms. They gave me a picture of a Rolls Royce with the license plate "PCD" that hangs in my home today.

Lilly, not satisfied, took the case to the United States Supreme Court. In June 1990, Justice Antonin Scalia (now deceased) delivered the opinion of a 6–2 majority that upheld the appellate court's decision, ending the ordeal.

The episode struck home the immense power of the courts, especially a federal court and a federal judge. But it is important to stick to your principles. With Medtronic's legal help, I was fortunate to be vindicated in the end.

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The Condolence Note

BY KATHRYN ZUG '88

The healing and solace I experienced through the many condolence notes I received after my brother's unexpected death last year brought back a painful professional memory that I can pass on in these words of wisdom.

Though I wish it need not have happened, this sad and regretful experience changed me.

I still carry with me the painful memory of a patient's spouse—some 20 years ago-- telling me how angry she was with me for not having sent her a condolence note after the passing of her husband. She kept away from the hospital and clinic several years because of it, she later told me. This was SO painful to hear. I had cared for her husband over several years, multiple visits, some agonizing, some hopeful. Together we made the difficult decisions on strategies to prolong his life from the Cutaneous T cell lymphoma which was outpacing his incredibly strong, courageous, and endearing spirit and livelihood.

According to the Merriam-Webster Dictionary, "When used in the singular, condolence generally refers to sympathetic sorrow, and particularly sorrow regarding the loss of life. It is used when speaking indirectly of that shared sorrow."

Notes: Inpatient, outpatient, operative, etc. The condolence note is not one amongst our MD note lexicons. You will not learn how to write it in "On Doctoring" or in residency. This is not the purview of Epic templates or other EMR. Don't be afraid to write that note to a grieving family or spouse. Handwritten and heartfelt, the condolence note is something you should be prepared to thoughtfully reflect on and put pen to paper. Seal, stamp, mail.

Your heartfelt words are a continuation of your healing mission and your depth of caring that goes beyond that mission. If you don't know how to begin, ask someone. Reach out.

Thank You

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- Our alumni who took time from their busy schedules to write one (or more) stories of wisdom to pass to their new colleagues.
- Everyone who has supported this project in the past, either philanthropically or through writing previous stories.

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