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DEDICATION

To Joanne Snapp

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1

NARRATIVE MEDICINE AND THE VIRTUE OF HONOR

Wesley J. Park[1]

Rita Charon says that narrative medicine is about 'honoring stories of illness'.[2] Trained as a medical doctor and literary scholar, Charon is a leader of the recent movement in medicine calling for a return to humanist values. In a system where physicians and patients are often treated as numbers, narrative medicine is a plea to take the narratives of illness seriously because they are worthy our honor. But what does it mean to honor a story? In this essay, I will offer a conceptual analysis of honor and consider the role of honor as an ethical virtue in narrative medicine. In my analysis, I argue that honor is best understood in relation to respect, moral rightness, and high regard.

The Oxford English Living Dictionaries offers the following three definitions for the entry on honor.[3]

(1) High respect; great esteem.
(2) The quality of knowing and doing what is morally right.
(3) Something regarded as a rare opportunity and bringing pride and pleasure; a privilege.

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[1] University of California, Davis (Editorial)

[2] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness*, Oxford University Press, 2006.

[3] *Oxford English Living Dictionaries*, Oxford University Press, 2018.

In what follows, I will consider how each definition illuminates an aspect of the role of honor in narrative medicine.

According to the first definition, honor can mean 'high respect' and 'great esteem'. This lends itself to perhaps the most natural reading of 'honoring stories of illness'. Illness narratives, which are stories about human suffering and sometimes, though not always, healing, constitute a flourishing literary genre. (The qualifier is necessary as illness narratives can also be a powerful way to discuss the limits of medicine and the nature of mortality. However, there is the familiar point that narrative reflection itself can be therapeutic. Thus, reflective self-expression through writing has been praised as one of the practical virtues of narrative medicine.) In the context of narrative medicine, the proper object of 'high respect' and 'great esteem' is the narrative experiences of patients, or one's first-person stories of illness. Therefore, the practice of honor recognizes the merited, quasi-aesthetic value of patients and the story of who they are. Human suffering is the most basic element of an illness. When we witness such suffering, it is natural to feel empathy in response, but we also have great respect for those who brave the battle against illness. This is one interpretation of 'being moved by the stories of illness'.[4] Good physicians, of course, continually engage in this process of being presented with human suffering, then responding with respect (and rightly so), and, finally, being moved by compassion to act. (This process that is part and parcel to the doctor-patient relationship, which itself is an object of 'respect' and 'esteem' in narrative medicine that I address later.) Honor reminds us that the stories of our lives, particularly those of overcoming challenges, importantly demand our respect.

According to the second definition, honor is about 'knowing and doing what is morally right'. This definition points to the connections between narrative medicine and the interdisciplinary field of narrative ethics, which can refer to either the ethics of patient storytelling or a narrative-based approach to medical ethics, among other things.[5] The recent scholarship in this field has led to fruitful insights into the nuances of different narrative subjects and their interrelatedness in bioethical contexts. Narrative ethics, according to Martha Montello, 'Fleshes out principles, so that we can see moral dimensions as embedded in

[4] Charon, *Narrative Medicine*, 4.
[5] See *Stories Matter*, Rita Charon and Martha Montello (eds.), Routledge, 2002.

the flow of people's lives and values. Often, then we can recognize decisions that fit with people's lives as they live them'.[6] In honoring the stories of patients, Montello argues, physicians-storytellers must develop a competence to recognize and appreciate the complex dimensions of values—moral and otherwise. Honor serves this important role as a characteristic way of reasoning that calls for an unassuming narrative humility, a deep-seated respect for patient dignity and privacy, and a charitable narrative portrayal. In other words, honor as a virtue of narrative ethics is about treating patients ethically in the telling of their stories.

According to the third definition, honor involves 'rare opportunities' and 'privilege'. This definition is perhaps the most relevant to healthcare practitioners. It is a reminder that caring for the sick is a worthy and estimable calling. Although many doctors will admit that their profession can at times be tireless and thankless (citing physician burn out rates), honor can serve as a reminder of the reasons that initially inspired one's decision to go into medicine. Accordingly, what is the value or goodness of the medical profession? Of course, one becomes a doctor to treat patients; and treating patients is doing right by them. But mightn't there be a further explanation? Surely, a skeptic who does not understand that helping patients is good may not have the capacity to understand why it is so. However, perhaps honor may prove useful in answering this further question. I argue that the physician-patient relationship is one of great moral worth and honor, not only for its social utility and the service of human dignity, but also for the necessary role it plays in human flourishing. Theists believe that they are called to live in accordance with God's will for the promise of 'true riches', while others seek the Good Life. In pursuit of true happiness, the medical profession aims to enable patients to live well and flourish, unhindered by illness, by the efforts of physicians, who, in so doing, are able to actualize their own purpose in life. In this way, the physician works for the sake of the noble—whence the honor of the medical calling.

In conclusion, I have offered a conceptual analysis of the word 'honor', using three definitions to draw out the interrelated concepts of respect, moral rightness, and high regard. In this reflection of honor, I hope to have shown how these three notions

[6] Martha Montello, 'Narrative Ethics', *Harvard Medical School Center for Bioethics*, Jun. 10, 2016.

illuminate different aspects of the role of honor as a virtue of narrative medicine. With a deeper understanding and appreciation of honor, there exists greater interpretive richness to the common phrase 'honoring the stories of illness' in the context of narrative medicine which involves, among other things, a respect for the narrative experiences and privacy of patients, narrative insights into medical ethics, and the role of the medical profession to promote human flourishing.

2
THE POWER OF A HUMANISTIC MEDICINE

Murtaza Khan[7]

After just 15 minutes of seeing Aya, Dr. Fredrick had to call it quits. There were too many other patients to see at the rural Alzheimer's care facility, and Dr. Fredrick was the only psychiatrist. As I helped Aya back to her room, I could already sense in her the confusion that all residents felt after their long-anticipated visit was cut short. 'Is that it? Did he know about my perfect behavior?' she asked anxiously. 'I'll be sure to tell him', I reassured her, but in the back of my mind, I wondered too. Would Dr. Fredrick understand the life Aya lived each day, with only schizophrenic and late-stage Alzheimer's patients for peers? Could he see past the anxious woman that she appeared to be during the short visit and appreciate the amiable individual she truly was? Most importantly, were 15 minutes enough to get to the root of Aya's problems? Our healthcare system apparently says yes; in 15 minutes, physicians are pushed to understand the symptoms, partner with the patient, and render treatment that alters personality, psyche, and neurophysiology—and, of course, document it all. I could tell Dr. Fredrick disliked this system too.

Still, I realize that 15 minutes with a physician is a blessing for many. At Clinica Tepati, where I worked with the underserved, I met patients who confessed that they had to choose between purchasing food or medication. Yet, when I would bring them

[7] UC Davis School of Medicine (Editorial)

food, they often felt too ill to eat; I realized that health was a need more basic than food. When I brought them blankets, I saw how even a small act of literal and figurative warmth could restore their spirits. When I immersed myself in our patients' stories and pain, spoke their language, and gave them space to speak openly about their ailments, I discovered the extent to which socioeconomic limitations stifled health. This process was key to determining the root of their problems. Patients would forego treatment because missing work meant they would lose their jobs. Others would take family members' pills because they could not afford medication.

Once I understood our patients' challenges, I took measures to combat them. Nevertheless, successful care lay not just in providing resources. When I met with my first patient, Jane, I immersed myself in her story and gave her more than just 15 minutes to share her challenges. As I had seen physicians do, I spoke in her native tongue, Spanish, and encouraged her to ask questions. Slowly, she opened up; uninsured, jobless, and morbidly obese, she felt hopeless. None of the medications she had been prescribed seemed to help, nor should they have. Medications do not solve joblessness or obesity, but nonetheless, these two factors still impacted Jane's health. After I told one of our physicians, he proceeded to spend an hour with Jane, letting her speak about her illness and life. I realized that the physician's role goes far beyond prescribing molecular receptor agonists and antagonists, that it is also about engaging in genuine, effective interaction to understand and appreciate a patient's narrative.

At Tepati, we embraced this philosophy of patient care, of 'fortifying clinical practice with the narrative competence to recognize, absorb, metabolize, interpret, and be moved by the stories of illness' as Dr. Rita Charon, one of the founders of the Narrative Medicine field, says (Columbia University Program in Narrative Medicine Mission Statement). As a result, patient compliance was extraordinary. Jane, who had first come to the clinic despondent, left motivated to start exercising.

I felt that this lesson had to be shared. Seeking to provide a space for future healthcare professionals to reflect deeply on their medical encounters and on the power of the patient health narrative, I co-founded the Narrative Pre-Health Journal (NPHJ), the nation's first ever journal of Narrative Medicine at the undergraduate level. NPHJ has blossomed into a community of medical storytellers and together, we've reached an audience of over 12,000 viewers. We hope to continue encouraging a culture of critically listening to and empathizing with patients as a means of

getting to the true source of their ailments and, ultimately, delivering the right 'medicine'.

I might be naïve to think that, in this day and age, it is possible to afford all patients more than 15 minutes with a physician, but I have seen, time and again, the immense benefits of humanistic medicine. I want to continue learning about how to restore not just health, but the human being behind the sickness. I want learn more about the science, the philosophy, and the art of healing. And, above all, I want to bring these lessons to healthcare at large.

3
AN EMERGENCY PROTOCOL

Brandon Nguyen[8]

As I stepped aside the computer to grab a cup of water, I couldn't help but notice the 922 code coming into D pod. As I peeked my head in along with a nurse I saw an overdosed patient for the first time stretched out on the hospital bed, screaming and gasping for air. Even though he lay on his back, he seemed to have towered over the physicians at his side.

Some residents gestured for me to enter the room. As I hesitantly moved past a group of surveying scribes, nurses, and social workers, I immediately felt the warmth of twelve bodies circulating around the patient. It was crowded. I could barely hear my thoughts above all the conversation happening around me. I looked to my left and right, and although it was loud and seemed that panic would ensue, the physicians and nurses had calm faces. Some restrained the patient's arms and legs, while others were grabbing ventilation equipment. The patient was moving, but the situation was relatively under control. Every person in that room had a job and they collectively worked together to do one thing: save the patient's life.

Suddenly, the patient jolted and flailed his arms wildly out of the doctors' grasps. His eyes continued to roll back as he salivated and lifted his head in a spitting motion. He was aggressive and out of control. I had an urge to jump in and help hold the patient

[8] University of California, Davis (Editorial)

down, but I knew this was out of my realm of experience. I peered over my shoulders to see if anyone would come in to help, but the room was already at capacity. Almost a full minute of chaos passed before the patient started moving in and out of consciousness.

I will never forget what happened immediately after. The resident at the nose of the room shouted, 'Listen up! I want to hear my voice, and my voice only!' Everyone froze and dropped what they were doing. All eyes were on her, including mine. I watched as she demonstrated fearless leadership: she delegated people to strap down, sedate, and ventilate the patient. I could see the room coming together. There was strong communication among the group even when the resident continued to talk over them. Moments later, the patient was completely sedated and the team continued to treat the overdose and maintain his breathing.

As I began to exit the room, one of the internal medicine residents exchanged a smile with me. She asked, 'Cool huh?'

Still in awe, I responded, 'It was amazing to see her take charge and unite everyone in the room'.

She cheerfully replied, 'Yup, I'm glad I came down here for my rotation. All this on International Women's Day'. I paused and again, what felt like the eighth time in the last ten minutes, looked around the room. Every single physician and nurse beside the patient was female. The resident who shouted instruction, was female. The nurse holding the breathing mask, was female. The woman in charge of strapping down the patient, who was twice her size, was female.

Only after she spoke to me had I realized there wasn't a single man caring for the patient. Despite his sheer physical size, the women in the room easily matched his strength. Through their dedication, the patient was able to recover and thank them for their service. Likewise, I am reminded of the importance of female representation in medicine. It is moments like these where people turn their heads and acknowledge that this field is no longer male-dominant. We can appreciate this step towards gender equality knowing that women represent themselves as determined health care workers. From women's health organizations to an all-inclusive Women's March, there is one thing that is certain: the future is female.

4
WE'RE ONLY HUMAN

Preeti Bhat[9]

By the end of my freshman year at UC Davis I was excited to finally be a part of a student-run health clinic. Volunteering at the clinic meant helping serve the homeless population. It was an opportunity to familiarize myself with their social determinants of health and what was needed in terms of providing them healthcare. I was eager to develop a better understanding of the humanistic side of medicine that goes along with physician-patient interactions; I was ready to serve the homeless population in whatever capacity that I could.

Since then, each clinic shift that I've had, I've left with a sense of satisfaction. Entering patient data into our electronic system, filling prescriptions, administering vision tests, taking patient vitals—it doesn't matter how big or how small the task is—I always feel like I'm helping our patients, bringing me an immense sense of joy. Equally enjoyable are our end-of-clinic debriefs. Preceptors, medical students, and undergraduates like myself gather in a circle to discuss patient cases. It's not uncommon to hear about patients who come in with high blood pressure, diabetes, and a myriad of other issues. Often times, we're able to help manage these comorbidities with not only health education but also with prescriptions like lisinopril and metformin. Mentions of how appreciative the patients are of the clinic are also brought up

[9] University of California, Davis (Editorial)

during this time. It's surprising how optimistic and gracious these individuals are despite their circumstances.

Yet, it wasn't until recently that the harsh reality of the other side of physician-patient interactions set in. It was just like any other clinic shift, all members gathered around in a circle to debrief. It's usually the med students who contribute first, but this time it was a preceptor. Dr. Q didn't wear his usual smile that day instead his face remained stoic. He started off by telling us that the patient came in with complaints of severe pain, had diabetes, and was experiencing kidney failure. We were also informed that the patient's in-house nurse, at the shelter that he was staying at, had asked him multiple times to go to his dialysis treatment. He, however, refused. While at our clinic, the situation didn't improve, the man's mood went from bad to worse, and he continued to refuse all medications and medical advice given to him. His prognosis was fatal, he knew it, the doctors knew it, the medical students knew it, heck even us undergraduates knew it, and no amount of lisinopril or metformin was going to help.

It was sobering to stand there and listen to the preceptor say this. He explained to us that the only option we had at the clinic was to both verbally communicate and put into writing on the patient's charts that death would soon be a likely outcome if further measures weren't taken. When the doctor said this, the silence in the room became deafening and expressions in the room turned from curious to grim. As we stood there in that circle, I realized that it's easy to view health professionals as these superhumans with the capability to help others regardless of the situation. Yet, it's also easy to forget that they're humans too and sometimes there will be cases when they'll be helpless. Going into medicine we know that death is something that is seen in the field, but until personally confronted with that reality it's just rhetoric.

That day I didn't leave clinic satisfied. I couldn't help but think of the man and his fate as I went to bed that night. The experience, however, didn't discourage me from wanting to pursue a career in healthcare. If anything, it brought more awareness and perspective to the way I approached patients at my clinic. Knowing that physicians and medicine have their limits, I better appreciate the need for primary prevention and am more proactive in my role during clinic to stress such measures. Even the way I communicate with patients is different, trying to avoid phrases and dialogue that can instill false hope, but still remain empathetic and willing to listen to the patients' stories. I continue to help my patients to the best of my ability because, ultimately, being in healthcare means

having the privilege to care for lives, but also the responsibility to be aware that we cannot play God.

5
LOOK, MA, NO HAND

Kyla Yamashita[10]

This fictional story is about a girl with Body Integrity Identity Disorder (BIID) and is inspired by my work from a class called 'Philosophy of Mental Illness'. I found BIID fascinating yet not prevalent or well-known. While studying Public Health Science—one of my majors—I found mental health to be a significant aspect of the field and, although I will be going into medicine, I believe it is so important regardless to understand and sympathize with the different issues people with mental disorders go through. 'Look, Ma, No Hand' is a story about a girl named Ida who has BIID and struggles to define her disorder and live a fulfilling life. She talks to her mother and doctors about her troubles and eventually takes matters into her own hands—literally.

I remember my life-altering day perfectly: it was raining, it was a Monday morning, and it was the day my fourth grade class took a field trip to the Museum of Natural History. I hopped out of the bus and looked up to see my best friend Macy holding her hand out toward me. I forced a smile and awkwardly grabbed it with my right hand, and we followed our classmates through the museum doors. I gazed up at the fake gray birds that hung from the ceiling inside, flying with wings spread yet frozen in space.

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[10] Santa Clara University

'Alright, class, follow me and we'll meet our tour guide, Mr. Riley', my teacher Mrs. Price announced, motioning us to keep close as we entered another room.

'Hello, Jim, so good to see you!' Mrs. Price exclaimed, extending her hand toward a man in a wide brimmed hat and a khaki uniform.

'He looks like an explorer!' Macy whispered to me. I rose up on my toes to try to see his face, heads blocking my view.

'Good morning, boys and girls', a voice boomed, echoing around the small room. 'My name is Mr. Riley and I will be your tour guide. Please, join me on a journey that will start through this door'. He held out his arm toward a doorway. I finally was only able to catch sight of his outstretched arm through the crowd. My eyes widened in awe.

His hand was missing.

Only a smooth, shiny stump poked out from his long-sleeved uniform. A sensation I had never felt before seemed to flow from my eyes all the way down to my toes like a type of magic had rushed into me. My curiosity and fascination grew with every second I marveled at his non-existent hand.

Apparently I wasn't the only one who noticed. Murmurs spread across the herd of fourth-graders that followed Mr. Riley through the doorway.

'Did you see? He doesn't have a hand!'

'What happened to him?'

'Maybe he was a soldier in a war and got his hand blown off!'

'It looks so weird!'

Mr. Riley pretended not to hear and we reached the first exhibit. He explained the history of something behind the glass—we all didn't pay attention to because we saw the real exhibit as his missing hand. I looked around and everyone's faces expressed disgust.

I admired the wondrous stump as Mr. Riley rambled on. I wanted to touch it. I wanted to ask him how amazing it felt to not have a hand. I wanted to be like him. I wanted to ask him why I wished to be like him and why no one else did. I looked down at my own right hand and the magic feeling immediately escaped my body. I didn't have a stump like Mr. Riley's. At the end of my right wrist was a hand: a hand that didn't belong. I didn't know why I was the only one whose right hand didn't belong. I glanced at my left hand and wiggled it, understanding its existence and that it was part of me. I shifted my gaze back to my right hand. It felt as fake and out of place as the gray birds in the museum, frozen and

stuck in the wrong time. Mr. Riley was a complete person with his stump, and I wanted to be complete too.

'Alright, sweetie, help me bring some of the groceries in the house', my mom told me, struggling to carry three bags in each hand. We had just returned from our trip to the grocery store after my middle school play practice. She had left a bag full of fruits and a gallon of milk sitting on the floor in the car to carry in. I stood outside the car and grabbed both, but as I pulled them out, an apple fell out and rolled next to my foot.

'Oops'.

I reached down to pick up the apple, placing my right hand on the car door frame.

'Watch your hand', she said, raising her foot to use it to shut the car door. I gazed at my alien right hand, frozen and spread out like a dead animal. My mom had turned her head toward the house and swung the door shut with her foot. I yelped but immediately examined my hand, disappointed to see it was only red and throbbing but not gone.

'Oh my God, Ida!' my mom shouted, grabbing my right hand and caressing it with more care than I had ever given it in my life. 'I told you to watch your hand!'

'I did', I stated with a blank face.

I tiptoed down the hallway of my house—it was 1:00 a.m. and I was a freshman in high school. Mr. Riley's missing hand and the fact that I wished my hand was gone too hadn't left my mind for years, and I wanted to better understand why. I slipped into the tiny room at the end of the hall and pressed the button to turn on our home computer. I opened a browser and looked up 'missing hand' in 'Images' and my dreams were displayed across the screen. The more I scrolled, the more I was exposed to a world that made sense: a life with an amputated hand. I would look up these types of pictures at least once every week over the next year, hoping one day I could be like the people in the photos. I would look at the pictures and then at my own right hand, acknowledging it was still there. My right hand just wasn't me, and I constantly felt disturbed. I knew this wasn't the way other people thought, and I knew no one stayed up late on Friday nights searching for amputated hands, but I couldn't help but feel like my hand didn't belong to me.

In my sophomore year of high school, I was scrolling through the images of amputated hands on a typical Friday night and

stumbled across a website called 'Wild Wannabes'. I was shocked when I scrolled through to find posts written by so many people that listed all of the thoughts I had over the past five years. One man described how his right leg felt like an obstacle to his happiness, and another woman said she would never truly feel whole if her left arm remained attached to her body.[11] I discovered that a 'wannabe' was a person who wished to amputate a healthy limb. I realized that throughout my life, I had felt like my right hand wasn't a part of me, and the thought of having it removed was absolutely thrilling. Rising from my chair, I raised my hand and my foreign hand up toward the sky. I was a 'wannabe', and I was not alone. I was going to rid of this right hand for good.

I walked into the kitchen the next morning and saw my mom chopping carrots.

'Hey, Mom, I have a question'.

'What is it, sweetie?' she asked. I watched her continue to chop carrots, mesmerized. *Chop. Chop. Chop.* She stopped chopping and looked up at me. 'What, Ida?'

'Oh, um', I glanced at my feet. 'I was wondering if I could see my psychologist again'. My mom placed the knife down next to the carrots and walked over to me.

'What, honey, I thought your anxiety had improved!' She grabbed my shoulders. 'Are you feeling anxious again? Is it school that's stressing you out?'

'No, no, it's something else. Can you just schedule an appointment for me?' My mom with concern in her eyes agreed and set up an appointment with Dr. Lee the next Saturday. On that day, my mom drove me to the office and as I was about to leave the car, she placed her hand on my shoulder again.

'You know you can always tell me what's going on, Ida', she said softly. I hesitated, but sat back in my seat to explain. I took a deep breath and turned to her.

'My hand is not mine'. She stared at me, expressionless. I shook my head, realizing that was probably the worst explanation I could have provided.

'Okay, try to imagine you woke up one day and had a third arm', I said. 'What would that be like?' My mom was confused but willingly played along with the hypothetical scenario.

'Hmm, I guess it would be a bit weird since I'm so used to having two arms'.

'Would you think this arm was part of you?'

[11] Johnston and Elliot, 432.

'I mean, no, because I only have two arms and this arm just appeared'.

'Wouldn't you want this third arm to go away because it isn't you?'

'Yes…' my mom responded, unsure of where I was going with the conversation.

'See, Mom, that's how I feel about my right hand. It doesn't belong to me'.

My mom laughed nervously. 'I don't understand… that is your hand, Ida. You do things with that hand. I don't know what you're saying'.

I sighed. 'It feels like that third arm I was talking about. I don't want my right hand on me. It isn't me. It doesn't belong there, Mom. I want it off of me'.

She said nothing for a minute, then spoke to me in a gentle, high-pitched voice, as if I was a crazy person she was trying to kindly distance herself from.

'How long have you been seeing things this way, sweetie?' She waited for my response, staring at me like I was an alien—like I was insane. She looked at me the way I would look at my hand. Then her face suddenly lit up.

'Oh, maybe I can talk to Uncle Sam about this. You remember Uncle Sam? He had delusions too so maybe we can find out how he stopped seeing things. Yes, we'll do that. Do you want to do that? I think we should do that'.

I couldn't believe she thought I was delusional. I glared at her for a second longer and turned away to open the car door and leave. I slammed it before she could say anything more and ran toward the office building for my appointment.

'Hi, Ida. It's great to see you again'. Dr. Lee closed the door behind him and took a seat across of me. 'How are you doing?'

I explained everything to him, hoping he'd understand better than my mom had half an hour ago.

He nodded. 'Yes, I've heard of this condition. It's called Body Integrity Identity Disorder or BIID. It's very rare, but I've read a few papers on it in the past'. He brought out a pen from his pocket. 'How long have you felt this way about your right hand?'

'Ever since I can remember, my right hand has always felt like it didn't belong to me', I replied. 'I only fully recognized how badly I wished to not have my right hand on my body when I was in the fourth grade and saw a man without a hand for the first time'.

'I see', he said, writing a few notes down in his notebook.

‘So, today’, I said and inhaled a deep breath, ‘I am here to learn how I can find a surgeon who can remove my hand’. Dr. Lee raised his eyebrows and stopped writing.

‘Did you say...remove your hand?’

I nodded confidently.

‘You know, Ida’, he said, ‘it isn’t legal for surgeons to amputate a healthy limb, and they could actually be sued if they did. There are also major ethical issues that would arise if amputation of healthy limbs was accessible to individuals with BIID’.

I frowned in disbelief. ‘But, but’, I stuttered, ‘I *saw* people online just like me who were able to get their body parts removed surgically’.

‘Well, those people probably got their limb removed through illegal ways or carried out the amputation themselves, which is very dangerous’, he warned, ‘as you could die’.

I shifted in my seat, aware that he was assuming things about me.

‘Ida, I suggest that you consider talking with me about it and see if we can figure out how to better handle the issue at hand in perhaps a less extreme way’.

‘I just don’t think counseling will help’, I argued. ‘Something is wrong with my brain. I looked it up. There is evidence that the parental lobe—’

‘Parietal lobe’, he corrected me.

‘Yeah, *that* doesn’t tell me my hand is there. That’s why I can’t identify with it and I’m not normal’.

‘That could be true, but there isn’t enough evidence to support that it truly is a brain malfunction’, Dr. Lee cautioned. ‘Also, even if justified, amputation of healthy limbs would lead the medical community down a slippery slope. So, Ida, I just don’t think it’s wise to expect an amputation’.

I pressed further. ‘I just don’t see why I am not allowed to get my right hand removed if I am perfectly normal and know it would make me feel so much more whole’. I started to tear up. ‘Do you know how hard it is to feel like part of you that you know is supposed to be you isn’t you?’

Dr. Lee handed me a tissue. ‘I know it must be really hard to deal with, Ida, and I’m sorry I don’t fully understand how you feel. But as of now, I do think the best option for you is to continue seeing me and we’ll try to get to the root of the problem psychologically’.

I nodded reluctantly, as I had hope that maybe I could one

day learn to accept my right hand as part of me.

I continued meeting with Dr. Lee for the next two years, but my desire to rid of my hand grew slowly overtime. I was depressed throughout high school and felt isolated and different. Everyone else could focus on school, their extracurricular activities, and their friends. All I could think about was my right hand and how this thing was still on me. I fantasized about cutting off the circulation in my hand to such a great extent that it would turn black and fall off or submerging it in ice for hours until it died. I knew I could never do these things though because the pain would be too slow and unbearable. My friends always made fun of me for being a wimp. During the summer, I wouldn’t even get tattoos with my friends because I couldn’t stand the idea of prolonged pain.

It was the first day of classes of my senior year, and my first class was Woodshop 2. I had taken woodshop the previous year, so in Woodshop 2, we would be able to use the equipment on our own with supervision. The teacher, Mr. Levinson, began class and told everyone to gather around the tools to explain the day’s task.

‘Today we will be cutting a few wood blocks into the following shapes’, he said, pointing to an image on the projector, ‘to eventually create a foldable stool. You will pick your wood type, come over to the radial arm saw, and I’ll explain the safety rules to each of you before you begin to cut the wood. I trust all of you have developed the skills from last year to handle creating this without much assistance’. Mr. Levinson clapped his hands together. ‘Alright, let’s get started’.

I took the entire class period to pick out my wood pieces. By the time class was over, everyone had cut their wood blocks to sand during the next class. I waited until the last person left the room. I caught Mr. Levinson walking toward me from the corner of my eye and pretended to examine the wood piece in my hand.

‘Ida, come on’, he groaned. ‘You have to pick something and at least cut today’.

‘Yes, sorry, I’ve decided’, I responded. He looked peeved but told me to follow him to the machine.

‘Okay, so you probably remember from last year, but rules are keep your hand at least six inches away from the saw on your wood block and use your dominant hand to pull the saw slowly toward you. Got it?’

‘Got it’, I replied. I put my wood block in front of the saw and placed my right hand six inches away on the wood and my left

hand on the saw.

'Oh, you're left-handed?'

'Yes', I lied.

'Okay, I'm going to turn it on, and just pull the saw slowly toward you until you hear a hum. That means it's done cutting. Okay?'

'Okay'. *Confidence, Ida, confidence. It'll be over before you know it*. The saw screamed. I held my breath. I placed my right hand in front of the saw and pulled with my left.

'Wait, wait, what are you doing?' Mr. Levinson yelled frantically. 'STOP!' He pulled my arm away but it was too late. The saw hummed.

I told everyone it was an accident. Mr. Levinson knew it wasn't but pretended it was too. I told the principal I cut the wood while Mr. Levinson was in the bathroom without his permission, so he wasn't fired. My mom of course knew why I did it, and even though she was mortified for a while, she eventually accepted me and told me she did notice I was emotionally a different and surprisingly better person. Although the recovery process after surgeons sewed my wrist up was painful—the kind of slow pain I hated—I felt alive. My friends pitied me, saying I lost a valuable part of my body and it was such a shame I had to learn to write with my left hand and couldn't play the piano anymore. To me, this didn't matter, and I really had gained something mentally by losing something physically. I was finally internally and externally complete. I didn't have something on the end of my wrist that didn't make sense. Nothing was there, and that made me the happiest person alive. I was finally like Mr. Riley, the tour guide on the fourth grade field trip: an explorer in a khaki uniform, ready to take on a journey through life's exhibits that would not be defined by my right hand.

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6
HELEN'S STORY
The Misguided Care of Nursing Home Residents

Mary Lee[12]

On a warm August afternoon, the residents had just finished eating lunch. While some were still mobile and could simply walk themselves back to their rooms after eating, most simply waited, bibs still on, sitting in their wheelchairs until a nursing assistant had time to roll them to the small waiting area around the nursing station. We each essentially walked laps, taking resident after resident to this small strip of striped 80's carpet. And each time I returned, I saw patients sitting exactly where we had rolled them, most closing their eyes, completely still, like frail statues. However, as I returned with the last of the residents and leaned on the nurse's station for a moment of rest, the scene transformed from the quiet garden of statues to 'Helen, Helen honey, can you sit up for us? Helen… oh my God, there's something wrong', to 'Get her upright… get her BP… get a cuff… get the RN'. I finally turned around to see one of our newer residents with her back slumped forward and her long silvery hair draping over her knees. As I looked around, I panicked with the realization that the CNAs eavesdropping from down the hall were looking at me, a brand-new CNA student with only a few weeks of training under her belt, as if I was competent to help deal with the situation. The charge nurse barreled down the hall to assess the situation and threw me

[12] University of California, Davis

a blood pressure cuff and stethoscope.

'Can you take her blood pressure?' she harshly half-asked me.

'Yeah', I replied blankly, barely loud enough to be heard in the chaotic situation.

Yet, as I was sealing the cuff's Velcro edges around Helen's limp arm, they decided she needed to be lying down on a bed, leaving me attached and breathlessly jogging along next to her as they wheeled her speedily into her room. By the time Helen was transferred to her bed and I was able to start taking the BP, the medical event, whatever it was, had ended. Helen lay conscious, wide-eyed, and with all the blood drained from her face as I inflated the cuff, then slowly let out the air. But the stethoscope was silent in my ears, I strained and squeezed my eyes shut trying to hear any familiar systolic 'whooshing' in her veins, but I couldn't get a read even as the meter reached very low pressures. I inflated again, deflated again, to no avail. My eyes shot around the room nervously before meeting the eyes of an impatient experienced CNA who stepped in to do it for me.

The next morning, I heard that Helen had had a TIA, commonly referred to as a mini-stroke, which was then quickly followed by a stroke soon after the NOC nurses had arrived. I felt a pang of sadness for Helen, knowing the isolation so common to residents in nursing homes after having an acute health problem. Unfortunately, I was assigned to another block of rooms for our next week and didn't have the opportunity to go into Helen room, where she stayed virtually every hour of the day, only emerging for a weekly shower. Then one lunch period, I happened to see the pre-wrapped lunch tray in the 'to be room-delivered' area labelled with a small, white tag 'Helen C. Room 13b'. I quickly snatched the tray and snuck away to her room, avoiding being assigned to one of the residents who needed feeding assistance in the dining room.

I knocked on Helen's door with the classic greeting, 'Hi, it's Mary Lee, your CNA, can I come in?'

I didn't hear any reply, so I peeked in the room, expecting to see her taking an afternoon snooze. However, Helen was lying there with the same wide-eyed look, mouth gaping open, rimmed by her dried-out, pale lips. I set down her tray, and nervously started small-talking to a woman who looked at me attentively, anxiously, but couldn't get out a reply. At first, she tried to pronounce a few words in response, but she could only make a drawn-out, throaty groan. Though I was shocked at the sudden disintegration of her state, remembering our pleasant and easy small talk just a couple weeks ago, I made a conscious effort to

shake myself out of my thoughts and treat her with the kindness I knew she would still understand and appreciate.

I asked Helen to point to what she'd like to eat first, unintentionally rejecting the practice of making residents eat their least favorite item on the plate first, which to me now seems to be unnecessary and degrading, treating an experienced adult like you would nag a child to 'eat their whole plate of broccoli or no dessert'. Her eyes twitched around the edges and gave a faint sparkle as she pointed to the bowl of bright orange cantaloupe on her plate. I handed her a fork, but it quickly became clear that her hand was not steady enough to skewer the cubes of fruit. Without thinking, I asked if I could help, and after she grunted a sound in agreement, I took over the fork duty. As I fed her, I chatted away, asking if she would like water, which food would she like next, and if it tasted good, as she worked her way through the meal. After she finished the entire plate, I started tidying up and stood up to head out of the room. She smiled and waved at me enthusiastically as I said my goodbyes and left the room.

I continued this ritual for a few days, but one afternoon, our routine would unfortunately change. As I was packing up, and tying up my own conversations at the end of her meal, she asked for water. Then more water. She forcefully coughed, seemingly in an attempt to clear the thick layer of phlegm that had gathered in her throat.

I was turned around, folding her blanket at the foot of her bed, when I heard, her scratchy voice clearly sound out, 'Thank you'. She put on a calm smile as I whirled around, shocked to hear she was able to speak. Wide-eyed, I said something like 'Oh my gosh, you're welcome! It's my pleasure to escape the hustle and bustle and help you'. I left the room in a rush, my eyes hot, as tears built up behind my eyelids. As I returned her tray to the dining room, I bumped into the RN who was sitting in the empty room scribbling down chart notes.

'I haven't seen you in here for a while, where have you been during lunch?' she asked dryly, somehow already displeased with the reply I would make.

I pushed the lump in my throat down and composed myself to answer cheerfully, 'Oh, yes you're right I haven't been in here much, I've been helping Helen C. with her lunch.'

'Are you kidding me? Who gave you authorization to do that? If you help her, she won't have a reason to relearn her ADLs. You're not allowed to deliver her lunch anymore; I'll have Bonnie take it to her from now on', she replied, and walked off in an angry

huff.

My mind went numb and blank, and I didn't even try to call after her to explain the situation she didn't care to hear about, that without someone's help Helen would be left alone, sitting in front of her food, unable to eat at all; that the hope for rehab just wasn't worth it. Though many residents are fairly independent and are encouraged to remain as such even as their health slowly declines with age, the value of rehabilitation efforts for extremely ill patients that are apparently near the end of life seems questionable. In general, nursing practice aims to sustain as high a quality of life as possible. I struggle to believe, however, that Helen had a higher quality of life after I was forbidden to help her: sitting alone, struggling to get anything onto her fork, for the sake of the slim possibility that she could somehow re-learn the skill of feeding herself after the brain and physical damage associated with her stroke. However, my opinion was and is meaningless. The role of a CNA is a challenging one in this way, where even though CNAs are the part of the health care team that spends by far the most time with the residents and gets to know them and their needs the most intimately (CNAs often become the closest thing to family that residents have left), their voices are given little to no weight in the clinical decision-making process that affects their residents.

After my measly 5 weeks working with residents, I've realized that for residents, feeding is one of the most important, and can be among the most problematic parts of what life in a nursing home means. It would be obvious to anyone paying a bit of attention that Helen wasn't able to eat much of anything at all by herself, and likely became malnourished very quickly. Unfortunately, this phenomenon of decreased food intake due to lack of care, as opposed to being due to weakening appetites or difficulty eating, appears to be a common issue in nursing homes. In the study 'Improving Food Intake in Nursing Home Residents With Feeding Assistance: A Staffing Analysis', which was published in *The Journals of Gerontology*, Sandra Simmons found that 50% of participants in 3 different nursing homes who were provided with individualized feeding care for a longer period of time (an average of 38 minutes per meal as opposed to previously having an average of 9 minutes of assistance) significantly increased participants food and fluid intake during meals. This research suggests the problem of low intake is much more complex than the dismissive CNA's explanation, 'They're not hungry',—that undereating could be a common, systematic care problem. Seeing this study made me

feel more confident in my decision to devoting extra time to help Helen eat; though not rehabilitative, it likely helped her keep her intake up which could give her the nutrition to keep a better quality of life and other aspects of her life in the nursing home. The willful ignoring of the assistive needs of a resident, that then ended my ability to provide care for Helen, is a form of the subtle neglect that takes place all too frequently in nursing homes.

Towards the end of my training, I noticed Helen glancing around with her large blue eyes, being wheeled into the dining room instead of the usual in-room lunch which she preferred. My confusion, as I saw her placed at the table of non-dementia affected residents who eat without assistance, was replaced with shock as I saw what she was handed—not her beloved plate of melon that she chewed so easily, but a 'mechanical soft' modified texture diet. My program had just told me that the only grounds to be placed on this type of diet was if residents had difficulty chewing or swallowing, which she had neither. How had this happen? Who had done this? But I already knew the only person who has control to alter the diet. I was angry at this invisible doctor, the one was responsible for our entire nursing home, whom I saw at the facility only once during my 150 hours working there. He was like a mythical creature, his signature gracing the occasional chart, yet never appearing in the flesh. The nurses would talk about him like a disconnected force that made the decisions without the necessary information. I felt the doctor had misdiagnosed her and prescribed an inappropriately modified diet, probably after reading a few words on her chart from after I stopped being able to assist her that said she wasn't finishing all of her food. The change seemed so blatantly uncalled for that it was difficult to imagine there was any actual observation or investigation of Helen's problem at all.

This lack of appropriate physician supervision in nursing homes is a significant problem which likely causes much of the mismanagement of nursing home residents' care. The issue of physician quality and time investment was examined by the U.S. Department of Health and Human Services in their comprehensive review of the situation, *Physician Practices in Nursing Homes: Final Report*. The researchers found that physician involvement in gerontology practice in nursing homes is minimal, with 77% administering no care to nursing home patients. Among the other 23% who practice in nursing homes, physicians reported spending 2 hours or less per week caring for their nursing home patients (Levi, et al.). As nursing homes and

elderly-focused care in general becomes more and more essential and as the baby boomer population grays, these bleak statistics pose the question: who will be there to care for this increasingly large population of elderly people? The lack of physician investment in nursing home practice may be traced back to the little coverage of gerontology in medical school education and training with only 10% of medical schools requiring a geriatrics course, and only 0.3% of residencies being in geriatrics (Levi, et al.). Ultimately, this has led to a vast shortage of physicians trained and qualified in geriatric care—only 2.5 for each 10,000 older adults (Levi, et al.). From this study, what we see is that not only do a relatively small percentage of physicians provide care for elderly people, but few of those who do are truly qualified to give the best care dealing for this population with very unique needs.

I sat down next to Helen near the end of lunch, and despite her focus attempting to use a spoon to scoop the pureed beef into her mouth, the look in her eyes when she noticed me there had an unquestionable tint of confusion and fear. Her brow wrinkle was more pronounced, her gaze strained and urging. She passed away a few days later, right at the end of my time in the nursing home. From doing what I was told, and contributing to the broken system of nursing home care, I was left with the permanent impression of the importance of patient contact and compassionate person-based care. Yes, a rehabilitative approach can be helpful in improving the lives of those with limited physical ability. But the needs of a patient, including their psychological and emotional needs, must be incorporated into a more individualized process of case management for nursing home residents.

From the *Journal of Advanced Nursing*, 'The Importance of "Knowing the Patient": Community Nurses' Constructions of Quality in Providing Palliative Care', by Karen Luker expresses a wider applicability of the lesson I soberly learned. Through interviewing 62 various levels of community nurses for the terminally ill, she finds evidence towards the perceived importance of the most promising emergent concept in nursing, 'knowing the patient', which she states has special applicability to palliative and end-of-life care. This type of care is much of the focus in nursing homes, and extends the applicability of this community nursing practice to my concerns in nursing homes. She finds that 'there is [a] general consensus that knowledge about the patient and their perceptions of a situation assists the nurse to interpret concerns or anticipate needs', which creates the best

quality of care for the patient (Luker, et al.). The process of getting to know the patient also 'fundamentally includes a sense of continuity and development of a close nurse-patient relationship' (Luker, et al.).

This evidence becomes the final push towards my conclusion that to provide personalized, compassionate care, we must improve the current system of detached nursing home care from typically un-invested and non-collaborative care providers. The ideals of care reflected in 'knowing the patient' which I learned from my time with Helen, have allowed me to feel some confidence in my inexperienced care-giving intuition that developing a relationship from persistent, individualized care is an essential part of providing the best quality of care. It has also irrevocably shaped my aspirations to become a primary care provider, where I will strive to create lasting relationships with my patients, providing them with the best care possible.

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7
MENTAL HEALTH MATTERS IN MEDICINE

Manpreet Kaur[13]

When I entered the obstetrics and gynecology clinic on the second floor of the hospital, Dr. Clark and a few other physicians were sitting in their offices and working on the last few notes for their patients. Dr. Clark starts her day at 7 am and stays until 9 pm almost every day to ensure that she has seen all of her patients and has completed their medical chart notes.

'I work 60 plus hours a week to treat my patients and finish their notes, and I absolutely love my job', Dr. Clark exclaimed when I asked her why she stays so late in the office.

Dr. Clark completed her residency in family and community medicine and psychiatry at UC Davis Medical School. She has also completed a post-residency fellowship in obstetrics and gynecology. There are only a handful of people in the United States who have this combination of specialties due to the stigma that exists against pregnant patients living with mental illnesses (Cassidy et al., 2003). Dr. Clark has created and sustained a mental health clinic called CONNECTED to serve the needs of

[13] University of California, Davis

Content warning: suicide and mental illness. This is dedicated to the struggling students who are trying to survive and succeed in an academic institution while living with mental illnesses and traumatic lived experiences. I see you, I love you, and I believe in you.

these neglected pregnant women. What started as a small project in her residency now serves over 300 pregnant and postpartum women at UC Davis Medical Center. Dr. Clark's own lived experiences have also inspired her to become a mental health advocate for neglected patients.

'We need more physicians and academics who are not afraid to address mental health issues. We need medical students who understand how trauma impacts a person's physical and mental health. We need pre-medical students who are passionate about treating all aspects of a person's health', Dr. Clark said as she wrapped up the last of her patient notes.

Dr. Clark's Path to Medical School

Although many pre-medical students finish undergraduate education in 4 years and attend medical school right after, Dr. Clark mentioned that there is a growing number of nontraditional medical school applicants. Dr. Clark was among those nontraditional students. She uses her story to inspire others to pursue their education and career goals regardless of how long it takes them or what others have to say about it.

'I remember going in to see an academic adviser once about going to medical school. She asked me if I meant to say medical assistant school. She did not think I was cut out to be a doctor', Dr. Clark shared.

Dr. Clark encountered many academic professionals who did not think she was capable of pursuing higher education because of her grades and lack of experience in academia. Growing up in poverty, she did not consider higher education to be accessible and did not start college until she was 23. Dr. Clark was raised by her extended family members, while her mother worked and her father lived in a mental health hospital with post-traumatic stress disorder. She worked as a receptionist in a law office, along with other odd jobs to make ends meet. She met her mentor at this law office job. He saw potential in Dr. Clark and encouraged her to pursue college. At first, Dr. Clark was very resistant and was convinced that she would fail her classes.

'He told me that everyone has the right to try and fail. He believed in me even when I did not believe in myself. It is so important to have mentors like him. I want to provide that support to others, I want to pay it forward', Dr. Clark said.

Dr. Clark emphasizes the importance of finding a mentor who can meet your needs and guide you as you navigate your

educational goals, as well as a mentor who can provide constructive criticism and is willing to invest in your well-being.

'Seek out and surround yourself with students, professors, professionals, and friends who believe in what you have to offer. Finding mentors can be difficult but do not be afraid to reach out to people who inspire you. Even an email or invitation to coffee can be the first step. Good mentors will sustain you', Dr. Clark shared.

Dr. Clark excelled in her courses and eventually worked as an intern at a center where she served the needs of autistic children. She wanted to pursue a career in pediatric nephrology, and her mentor helped her to apply to medical school. She was accepted into UC Davis Medical School and was part of the first class in history to have a majority of women medical students. Her experience in medical school, however, was difficult as she struggled with her mental health and traumatic loss.

Mental Health Stigma in Medicine

'In hindsight, I was clinically depressed the first two years of medical school. I was miserable. There were no counselors, and my professors never checked in with me', Dr. Clark recalled.

Dr. Clark talked about how she did not fit into the academic world because of the politics of professionalism, something that came easy to her privileged classmates. She explained how people did not understand her because of her colloquial speech and mental health struggles. She was insecure about her ability to read and write as eloquently as her peers from wealthy and highly educated backgrounds. Dr. Clark talked about how stigmatized mental health is in the healthcare field, not just for patients but also among healthcare providers, students, and academics.

In her third year of medical school, Dr. Clark's cousin committed suicide. She found out a few minutes before a class and was left in a state of shock. Her professor did not let her leave class and threatened to fail her if she left. Dr. Clark began crying as she told me this, and shared that she had not talked about this experience in a long time. After her cousin's suicide and her own experiences with depression, she became passionate about mental health advocacy.

'No one talks about mental health', Dr. Clark explained. 'There are more resources now. Access them if you are struggling. Do not be ashamed'. Dr. Clark refers to counselors and therapists who are available at both the UC Davis main campus and the UC Davis

Medical School campus. She mentioned that the stigma is still very real, and she hopes that her clinic provides a safe space for her patients to talk about their mental health.

CONNECTED Mental Health Clinic

Dr. Clark pursued a residency in psychiatry and family medicine because of the stigma she experienced and observed with mental illness. During her residency, Dr. Clark encountered a pregnant patient who was having a mental health crisis called psychosis. She admitted this patient in the psychiatry department but was immediately reprimanded for doing so.

'Psychiatry did not want to be responsible for this patient because she was pregnant. But the OB/GYN department did not know what to do because her issue was a psychiatric one', Dr. Clark explained. Neither department wanted to be responsible for this patient. Dr. Clark pursued a fellowship in obstetrics so that she could be a better provider for pregnant patients. She quickly discovered that the disconnect between psychiatry and obstetrics was failing to support many women who were experiencing maternal mental health issues.[14] This led to the birth of CONNECTED.

At CONNECTED, Dr. Clark provides medication management and group therapy to pregnant women who experience anxiety, depression, personality disorders, and other mood disorders. The clinic does not receive any outside funding, according to Dr. Clark, due to the lack of investment in mental health services and resources. The clinic is completely volunteer-run and relies on the commitment of Dr. Clark, her co-facilitator, and a team of undergraduate students. The patients discuss their psychiatric medications openly with the group to destigmatize the use of safe psychiatric medications during pregnancy. The women provide support to each other in coping with issues such as childhood trauma, abuse, and lack of attachment to their baby. A group of undergraduate students call the mothers weekly for a mental health check-in.[15] Dr. Clark screens pregnant patients who are at a higher risk of developing mood disorders during and after pregnancy and refers them for services.

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[14] The disconnect and lack of communication between the two departments was failing the pregnant and postpartum women who needed mental health services.

[15] We call them all mothers, even though some of them are pregnant.

‘Mental health is a public health and social justice issue. So many people are affected by it and the medical field needs to do better’, Dr. Clark strongly voiced.

Dr. Clark’s Role as an Agent of Change in Medicine

Dr. Clark is changing the culture at her hospital regarding mental health. Other providers now screen pregnant patients for risk factors of maternal mental illness. Physicians, medical students, and residents have shadowed Dr. Clark’s clinic to learn more about treating their patients’ mental health issues. She has presented at multiple mental health conferences regarding her clinic and treatment protocol.

Currently, Dr. Clark is working on a textbook chapter about maternal mental health and the importance of having resources for these patients. Medical students, residents, and physicians will use the information in this textbook to provide a higher quality of care for patients living with mental health issues. Dr. Clark believes that it is her obligation as a healthcare provider to spread this knowledge through her writing. Dr. Clark has inspired me to strive for a career in medicine even though I have my own struggles with mental illness. This interview was very healing and validating. Dr. Clark emphasized the importance of recruiting future doctors who have experiences with mental health issues because these experiences can create more compassionate providers. She plans to continue staying in her office until 9 pm if that is what it will take to provide the best care for her patients.[16]

[16] CONNECTED Clinic recruits undergraduate volunteers once a year during Spring Quarter. If you would like to get involved, please email connectedhealthclinic@gmail.com. Students living with mental illnesses are especially encouraged to apply.

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8
SET TO MUSIC

https://youtu.be/qJdrfaAGypk

Heather Nguyen[17]

I have captured glimpses of my senior year, in which I reached a turning point in deciding my career. My pre-health pursuits do not match the stereotypes that I have encountered over the past four years, but I believe that some viewers will resonate with my experiences and be encouraged.

[17] University of California, Davis (Video)

9
PRE-HEALTH STUDENT STORIES

While working as an EMT one night, there was a call for a suicide jumper on the cliffs. Upon arrival, I saw a pile of firefighters and policemen on top of this 16 year old girl, trying to put a spit mask on her. The group of men worked as if they were wrangling a wild animal. Once she was placed in the ambulance, it was just her and me in the back. A lot of times we perform CPR or some other form of a life-saving procedure, but this case stood out because none of that was needed. I found that by just talking to her and treating her like a human being, I was able to make the most impact. She was so grateful for that human touch that, by the time we reached the hospital, she didn't need to be sedated. I realized that treating individuals as humans through meaningful and empathetic communication can go a lot further than you would expect. On a similar note, being a Health Professional Advisor here at Davis has given me the opportunity to interact with a lot of pre-health individuals. It's made me more aware of how much I dislike the notion that all pre-health students are these Type A personalities who are out to fend for themselves and not help others. Especially here at Davis, I've seen that many pre-health students are welcoming and happy to help each other. It's important to try to see beyond the surface of those you come in contact with and make a real effort to understand others, because you just never know what type of impact you could have on them.

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When I started at UC Davis, I had no idea what I wanted to do in terms of career and the organizations and clubs I wanted to join. All I knew was that I wanted to major in biomedical engineering because I enjoyed math and physics. But I also liked helping people. Eventually, I saw healthcare as a viable career choice for me, as all of these interests of mine seemingly intersected in this field. It was also at this time that I was taking a lot of engineering classes, and many of these classes made me feel that their vision of the future involved automation of everything around us including our jobs. The human touch or factor would essentially be lost. This made me realize that I enjoyed the person to person contact involved in medicine and the hands on problem solving that came with it, pushing me further along this path of pre-med. However, the biggest indication of this actually came in my sophomore year of college when a friend of mine told me he was suicidal. I wasn't really sure how to handle the situation, and I tried my best to support him. It's what prompted me to become a wellness ambassador for UC Davis. I wanted learn more about mental health issues and how to help. I think that among pre-health individuals, there's a huge stigma when it comes to obtaining mental healthcare because many don't believe in it or feel that it's useless. Yet, I feel it's a topic that more and more people should be engaging in conversation about in order to reduce and eventually eliminate this stigma. If you really think about it, reducing this stigma would allow for a person who may have never seeked help for their issues before to feel more comfortable doing so and possibly benefit from it; that's a huge win for them. The more I educated myself about mental health, the more motivated I became to pursue medicine. I see myself as a future physician who is able to help in diminishing this stigma. I want to be a support not only for college students, but also for others who are dealing with tough circumstances related to their mental well-being.

It was like one of those things where your parents didn't really want to tell you. My dad was having a lot more appointments than I was used to, because he was the kind of person who would never want to go to the doctor at all. He hated the doctor, and all of a sudden he was having these appointments weekly. I was asking my mom what's going on, and she was like "Oh no, there's just something wrong, he's just a little sick, probably pneumonia." Each week, it seemed he was going in more often. Then, around senior year of high school, a malignant tumor was found in my father's lungs, and he had to be admitted for surgery. I honestly don't remember a time when I cried more than sitting in that waiting room, waiting for my dad to come out of surgery. The procedure went well, and the efforts of the doctor spurred me to want to become a physician myself. It's why, when I first came to Davis, I was so set on being pre-med, and one of the first healthcare volunteering experiences I had was through HRI and ICC internships. Yet, during my time volunteering, it hit me that most of the hands-on work was done by the nurses. They were the ones I got the most contact with, and I saw first-hand how they got down and dirty in their work. I'll never forget helping a nurse hold down an infant to get an IV inserted. With further self-reflection, I realized, in retrospect, it was the nurses that were so accommodating during my father's surgery, comforting and sympathetic to not only to me, but also to my mother and brother who were also visibly upset and in a complete emotional mess. These experiences geared me towards pursuing nursing instead. I hope that one day I will be able to pay it forward and be that emotional cushion for other families.

As a medical student, what advice would you give to others thinking of pursuing medicine?

I think the best piece of advice I could give would be to always try to think of your future patients and how you would like for them to be served. Personally, I thought that one way I could better myself to serve folks in the clinic I volunteered at during my undergrad would be to have a better understanding of the sciences. In that regard, I pursued neurosurgery research because I felt that research would help me understand what the cutting edge is right now and how that translates to patient care. At the same time, I wanted to learn more about some of the issues patients suffer from outside the clinic that impact their healthcare. This is where I think college is a great time to explore those issues, because you don't really get another chance to do so. I volunteered at a community health center where I helped with a prescription program that required applications and interviews. Patients would come in and talk about some of the struggles they faced and why they needed the program to afford medications for chronic diseases that they suffered from. I had a window into understanding the lived experiences some people have, how those experiences impact their health, and what that means in terms of providing them healthcare. If you feel that your patients deserve a high quality of care and more importantly deserve your total investment in their issues, you will not only have the motivation to study harder, but you will also have the motivation to address some of the issues in healthcare that go beyond what's in the clinic.

Pre-Health Student Stories Repost | January 19

I'm a fourth year Biochemistry and Molecular Biology Student planning to minor in Education. My peers motivate me as a pre-health student. Truthfully, it would also make my parents very happy. Once you've realized your career choice, you're naturally surrounded by those with similar goals, and I am driven to do well and pursue my goal because everyone around me is also doing the same. Seeing the light at the end of this tunnel of constant studying helps keep me going every day. It's hard because everyone is at a different pace, and sometimes others have different things on their plate at a given time. You'll definitely struggle and feel like you've hit rock bottom, but remember that there's nowhere to go but up.

Pre-Health Student Stories Repost | June 8

It's a given that GPA is one huge aspect that medical schools look at to determine if you can handle their vigorous workload, but it doesn't and shouldn't define you as a person. During my freshman year at UCD, my mother suffered a heart attack at work and was fired the next day. I spent my weekends going home to take care of her. My grades took a toll because I didn't know how to effectively strategize my time. It was a vicious cycle—the more weekends I spent going home, the more I stressed about exams. The stress exacerbated my poor academic performance, which made my mom even more ill. By end of sophomore year, my GPA fell below 2.6, and I re-evaluated my future goals in the health field. I've worked very hard the last 3 years of college to bring my GPA back up. Even though my current overall GPA isn't ideal for medical school, I wouldn't change my past. I struggled, but I persisted. Without my mistakes, I wouldn't be half the person I am right now—compassionate and confident. Always give your best. Stay calm, don't stress, and everything will work out.

Pre-Health Student Stories Repost | November 10

My journey, which some refer to as ‘pre-med’, might be better described as a journey of self-realization. Many who start this journey have a mindset that overly emphasizes the ‘pre-’, but I have come to a place where I focus on who I am, where I am—present tense. In one sense, I do not consider myself ‘pre-’ anything because higher education isn’t merely a stepping stone to some profession for me. During my gap year before studying at UC Davis, I became aware of the fact that many high school graduates never choose to attend college at all; in the privileged, college-prep environment in which I grew up, this would be unthinkable. My paradigm shift gave me a newfound appreciation for the opportunity to pursue a bachelor's degree, and in doing so, allowed me to grant myself the permission to study what I truly desired—*wisdom*. The word ‘philosophy’ is Ancient Greek for the love of wisdom. Despite the common misconception that studying biology is the only or best path to medicine, I chose to study what I am passionate about. While there have certainly been some challenges along the way, my research project in graduate-level seminars in ethics have been particularly rewarding. With post-graduate plans to apply to M.D./Ph.D. programs in bioethics—the intersection of medical science and philosophical ethics—I have eschewed the traditional pathway to medicine in my journey to become a physician.

Pre-Health Student Stories | November 23

Have you faced any significant challenges as a student?

It's not really one but a pattern. Being pre-med, a lot of things are competitive. You tend to get rejected a lot; there's a lot of rejection in it. And I guess one of the hard parts is learning how to deal with that rejection. Whether you're applying for research, clinic, jobs or anything like that, there's always going to be some rejection to face. It's hard to deal with at first, but in the end, it makes you a more resilient individual. I've always had friends and family supporting me and telling me to just keep trying, and, eventually, I started believing in myself more. It was somewhat hard for me to believe in myself initially, but after a while, things started to work out after trying so hard, and I started to have more faith in myself.

Pre-Health Student Stories | November 02

Last year, when I shadowed a burn surgeon, one case involving a 16-year old boy had a particularly deep impact on me. When I walked into the ICU, I saw the boy incapacitated, unable to talk, with a trach tube in his mouth and both legs amputated. I remember wheeling him into surgery. He was frantically blinking, and I could tell he was scared. Even worse, when we stepped into the operating room, no one talked to him. Instead, he was placed on the table, where doctors immediately took his clothes off and cut into the burn on his chest. As the surgery began, I felt like I couldn't breathe. I felt I would throw up. While staring at him, I thought I wasn't emotionally competent for the medical field; I couldn't bear to see people suffering to such an extent. It made me question how I could help others if I couldn't even hold it together when they needed me to. I tried staying in the surgery. I tried looking at him. I tried to maintain my composure. But 10 minutes in, I could no longer contain my emotions, and I ran out of the room and cried in the bathroom. I never made it back in because I was so emotionally overtaken. Later, after the surgery had ended and I had time to cool off, I talked to the nurses and the physician about the situation. They gave me a piece of advice that will continue to stick with me. They told me that I shouldn't focus on the condition a patient comes in with, but, rather, on the future I will be able to help provide for them. I shifted my thinking from doubting myself to understanding that my strength, which I realized, through my reaction, is that I'm a compassionate and empathetic individual. I wish the best for the patients I encounter because I genuinely care about them. Having that emotional reaction not only affirmed my passion and desire for helping people, but it also reassured me that with more experience and training, I will be better able to cope with the emotional side of medicine and focus on the positive.

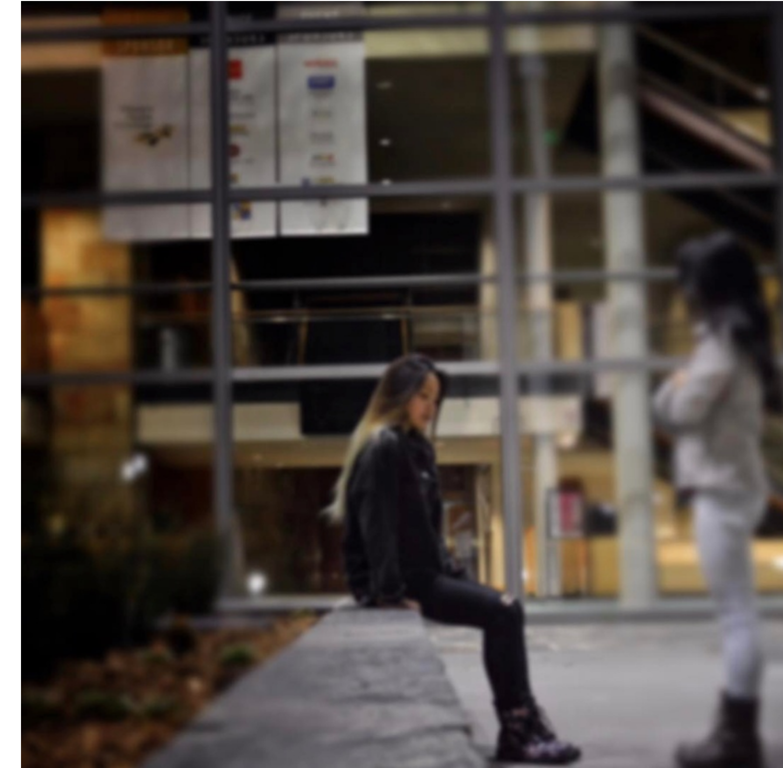
At my clinic, we see homeless patients who don't have access to healthcare – they cannot afford quality nutrition, let alone medication. This led me to think about my own family history, as my family is low-income and faces language barriers that make it difficult to communicate with doctors. That's why in clinic, being able to understand and attend to each patient's needs is very rewarding. Very recently, for example, one of our doctors recommended a patient obtain a certain cream for her condition. However, the patient expressed concern about not having the money and transportation to obtain the medication from a drugstore. Fairly new to the clinic, my doctor didn't know which medications we had in stock. So I looked into it. I knew that there were some medications that we could give her, and, after mentioning it to the doctor, we were able to prescribe and hand her the medication that day. Stepping up and taking initiative for a patient made me realize that, by giving patients medication, we are giving them hope. Drugs have the potential to cure people of sickness and disease, but only if they have access to them and are instructed on how to use them correctly. Each patient is different, and it is important to take into account individual circumstances that may prevent them from getting the help they need. Taking these barriers into account and remedying them is the job of a pharmacist. In the future, I want to continue seeing underserved patients and providing them with the healthcare they deserve.

I was so excited to conduct a nutrition consultation during my first internship day. However, little to my knowledge, the community member I was assigned to had several health concerns that fell outside the Type 2 diabetes and hypertension related issues we were trained for. These matters encompassed a strict diet that prevented her from eating healthy foods she actually enjoyed, and kept her from doing day-to-day tasks which lead to a heavy reliance on a caregiver. Despite the community member's health status, this caregiver would not follow the medical diet the patient needed, leading this individual to believe that a prescription meal plan may change her caregiver's actions. Due to time constraints, we scheduled to meet during my next shift; however, so many things quickly fell through the cracks. At the core of it, there was ultimately an inter-organization conflict paired with the registered dietitian's inability to do anything unless a physician was present. I tried finding solutions to each of these, such as partnering with another clinic, but this could not happen due to the conflict occurring. Although I was very frustrated, as I couldn't even go back to discuss other options with this individual, it quickly disrupted my own biases and exposed me to health care inequity. Furthermore, it showed me the different experiences people may have regarding health and nutrition, and the bureaucratic concerns that may prevent resources from getting to individuals. Although I realize that there are going to be (and there should be) barriers such as regulations to keep people safe within any profession, I want to pursue something that will give me enough power and education that will allow me to bring the best possible resources to the communities I serve. To me, health is freedom. And with that said, I especially don't want the bureaucratic nonsense to be a barrier that prevents someone from reclaiming their health and ultimately their life.

I watched my grandpa decline from a strong, cheerful, hard-working man to an 84-year old who could barely speak, eat, or move his limbs. It was painful to see how a stroke could completely change a person's life. After a few more strokes, the person I knew to be unstoppable was paralyzed and bed-bound. And then, in less than a few months, his health declined even more, and he was placed on hospice care. In the year and a half that I cared for my grandfather, I learned more compassion, love, and care then I knew was even possible. Seeing him become more dependent on our care was an eye-opening and life changing experience. Although I was in high school and my knowledge of medicine was limited, I was able to provide good care to my grandfather with the help of nurses and doctors. Even if it was the simple everyday tasks like eating, bathing, grooming, hygiene care, and administering pain medications, it was beyond what my grandfather could do on his own. In the end, it was the weak squeezes of my hand, his smiles and silent thanks that inspired me to pursue a career in medicine. Although my journey towards achieving my dreams has just begun, the opportunity to care for more people will be worth it all.

Pre-Health Student Stories | May 4

I woke up to my dad's phone ringing at 3am, to which he answered and said, 'which hospital is she at?' Immediately I knew it was about my sister. When we got to the hospital, the doctors said that there was a chance she'd survive but that there would be complications because her internal organs were ripped apart when she drove her car into the wall. I was both terrified and relieved because there was a chance she could be saved. The doctors came in a few minutes later and said that she didn't make it. That moment felt so surreal, and I was in so much shock that I didn't react. It was the first time I saw my parents cry, and I felt helpless. It wasn't until I saw my sister's lifeless body on the hospital gurney that reality hit me, and I burst into tears. To this day, coming again to the realization that she's really gone feels so surreal. I usually don't like to put my private life out there for others to see, but I knew that people would start talking and eventually ask me what happened... I didn't tell the story, but just that she had passed away. It was honestly a little frustrating to have to answer everyone's questions when all I wanted was to have time to grieve on my own. When I got that text from you about your sister, I didn't know what to think. I talked to her the day before. She asked me how I was doing abroad, and I told her that she would be the first person I recap once I come back home in a week. It was just one more week... It's strange to think that she knew we weren't going to have that conversation. I remember the last thing she said was that she loved and needed me. I loved your sister too, I really did. She was one of my best friends. You remind me of her.



I was taking his vitals and naturally having a conversation with him. I didn't really think too much of it. I was treating him like I would any person, but in his eyes, I could tell that was something he rarely experienced. He said "Wow, you were the first person that actually listened to me in a really long time." He got his abscess checked in the hospital a few weeks before, and the health professionals there shunned him. They tried getting rid of him as soon as possible and didn't want to listen to the other concerns he had... My mom had a different experience when she was diagnosed with breast cancer. That was really scary for her because that was the last thing she expected. After seeing how nervous she was for her visits and surgeries, I could see a big change in her. I met her doctors, and they all had the same thing in common. They were very good listeners and open to be there for her emotionally. They gave up time to answer her emails - even if some people might have thought of these as minor concerns. But for her, it made the whole treatment process so much easier. Something as simple as sitting down and listening opened my eyes about the importance of treating patients with compassion and what it means to be a good health professional - no matter who you're treating.

During my shift in the Emergency Department, I enrolled a patient into our influenza-detection study. While I was briefing the patient about the study he qualified for, he seemed hesitant and uncomfortable. Sick with the flu, the patient was weak, tired, and definitely not in the mood to have a swab 3 inches up his nose. The patient was harmless in presence and soft spoken throughout our conversation. His vulnerability made me feel guilty for approaching him. Even in his weak condition, the patient ultimately agreed to be a part of this the study. He said, 'For the advancement of medicine, I'll do it.' Since then, these words have reminded me that small sacrifices go a long way. His contribution will be remembered when this study advances and betters the treatment for future patients. Although the research study was voluntary, the patient knew that the outcomes would be well worth his nasal swab. Like him, I share the same responsibility of putting others before myself. I am able to relate his brave effort to my career goals in medicine, specifically to global health care. This type of outreach requires people to step out of their comfort zones and help those in need. Because many risks come with working abroad, health professionals are often uncomfortable providing care. I possess the same mindset as the old man: 'If it isn't me, who will?' I continue to ask myself, 'If it isn't me providing care to underserved populations, who will?'

Pre-Health Student Stories | October 27

It's tough to be a pre-health student when it seems like everyone around you is getting more internships, taking part in more research, or just landing better positions. It's like an ongoing competition that seems to go on forever until you're able to get into that one school. In freshman year, I was caught up in how behind I felt compared to everyone else and started researching alternative career choices. After asking a friend for advice on whether or not I should switch tracks, I also mentioned that becoming a doctor was a dream that I'd had for a long time. In response, the friend said, "Just do what you want to do." Although she meant those words casually, they've stuck with me for a while. I realized that nothing was stopping me from going after what I wanted except myself. Other people are just a distraction. I think it's great to be supportive of your friends and everything that they accomplish, but you should be just as appreciative of your own accomplishments too. Since then, I've found it a lot easier to get over that road block of worrying about whether or not I'll be successful, and I can just do what I want to do.

I used to volunteer playing music at a pediatric palliative care facility. We once had a nineteen-year-old with terminal cancer come in who begged us, "Please, don't tell my baby sister I'm dying." Two days later, I was doing the rounds with my guitar when the patient's sister -- six years old, cute as a button -- came up to me and asked if I would help her sing a song for her family: The Band Perry's "If I Die Young." Nobody had told her what was going on, but she knew. We didn't end up singing for the family, but I recorded us and put it on a CD for the little girl. When I recounted this to the facility's medical director, I half-expected her to scold me for overstepping, but she simply patted me on the back and said, "We don't just treat patients here. We treat families."

The

Narrative Pre-Health Journal

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ABOUT THE NPHJ

The Narrative Pre-Health Journal (NPHJ) is the preeminent undergraduate peer-reviewed journal inspired by narrative medicine. NPHJ is based at the University of California, Davis.

Our mission is to mirror narrative medicine on the undergraduate level across all health professions. NPHJ provides an opportunity for pre-health students to collectively share a multitude of experiences as aspiring health professionals through discussion, writing, art, photography, and virtually any other creative form.

The individual authors are responsible for using pseudonyms for patients and providing proper citations where appropriate. Every effort has been made to comply with the HIPAA Privacy Rule in order to protect patient privacy. The editors cannot be held responsible for any instances of plagiarism. If there are any ethical concerns, please contact us at narrativeprehealth@gmail.com.

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