



THE FORGOTTEN TEXT

Narrative Medicine from an MD/MBE Student

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Narrative Medicine
from an MD/MBE Student
&
A Component for the Fulfilment
of the Practicum Requirement for
Masters in Bioethics

By Vivian V. Altiery De Jesús

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Acknowledgements

This section is very important to me, a lot of people had an impact in my formation as a person and as a physician \(*o*)/. It is a little bit long when compared to the conventional acknowledgment section...but if the previous emoji gives a hint at all...this will be far from conventional (^.^). No, I don't think this is an Oscar either (¬o¬) I think I could make an index for this though lol*.

*To **my family** who were there for me since the beginning of times. Especially my two younger siblings, Vivian A. Altiery De Jesús and Julio A. Altiery De Jesús, who read and read — and lived with me — my narrative medicine. To Mom who gave birth to me, raised me, and encouraged my curiosity since I was little. Thank you for supporting me and having my back in this adventure we call life.*

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*lol = laughing out loud

Preface

Perhaps the best way to explain this would be through a small map. *The Forgotten Text* takes places between my third and fourth year of medical school while doing my master of bioethics (MBE). The timeframe ranges from my undergraduate senior years, first through third year of medical school, and the MBE(^.^). The goals of *The Forgotten Text* are:

- Describe and analyze impactful scenarios during my medical formation at the medical student level.
- Apply the Ethics Framework to Clinical Cases
- Capture the fluidity and spontaneity of the encounter

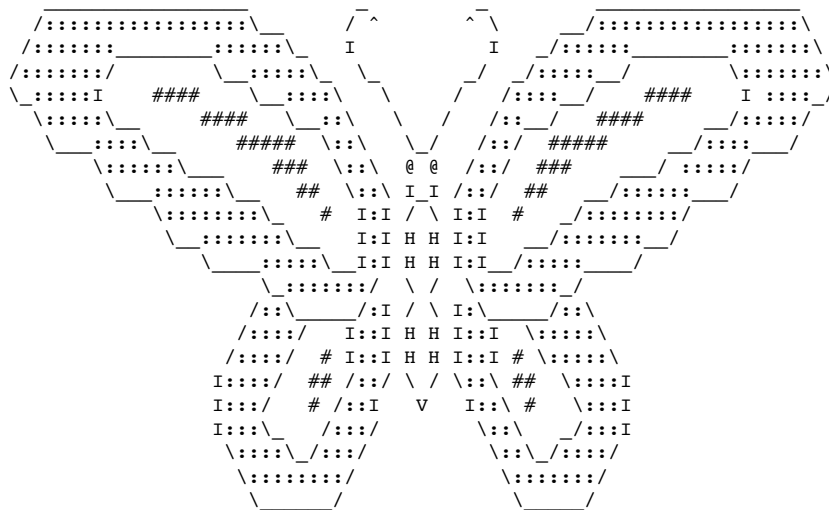
The Forgotten Text compares the physician identity formation to the butterfly metamorphosis, where the medical students—and maybe other trainee stages—are transformed into physician through the mysterious space of the chrysalid(@o@). A limitation is that the medical education process is constrained to one point of view. However, I hope that through the narrative we can engage in conversations that may help improve medical education. Some may feel identified, others not, which is completely normal(¬.—). Either way it is a chance for awareness, auto-feedback, and collective feedback.

Why the emoji though? (o_O) Well, I was born in 1992 a borderline millennial-centennial...yeah, yeah I had a glimpse at the SEGA Genesis, grew up with Play Station 1 and Nintendo Game Boy Color (---) *My point is not look like a dinosaur, trust me* (¬_¬). More importantly, I grew up writing with emoji and shortening phrases to mere initials *BC it is GR8 & AWESO!* (Because it is great & awesome). It would be painful to write and read—at least for me—a long piece using texting abbreviation (>_<) but not emojis (XD). I use emojis in *The Forgotten Text* has a footprint of my timeline, a way to record my reality.

The text is truthful, but I warn about another limitation regarding narrative medicine—some situations, especially with patient interaction, are not verbatim. I promise that the essence of the problem, issue, concerns are real, but patients' identifiers and locations are distorted which, as mentioned in Chapter 5, is our duty to our patients.

Without further ado (^_°)/ I present to you *The Forgotten Text*, a bioethics field experience and narrative medicine from an MD/MBE student. Hope you enjoy ❤️!

The Forgotten Text: Narrative Medicine from an MD/MBE Student



Medicine is My Third Language and Narrative is My Fourth

Chapter 1

The first year of medicine was one of fascination and wonder (☹ ~ ☹). The school tossed us a long list: stethoscope (Yeaay!), white coat (why short though (¬o¬)), tuning fork (whaa? (☹ _ ☹)), pen light...I expected endurance training with blood, human organs and astonishing CPR techniques. For some odd reason, my conception was between a slaughterhouse and the fancy TV shows where *everything* is solved with CPR... (-.-;) Who could blame me? I was over the moon with the Cardiology Stethoscope and the coat \ (^o^) /. I remembered my kindergarten homeroom teacher. It was “profession day” and the school wanted kids in professional costumes (the joy (¬.¬)). I remember saying proudly, “I want to be a doctor!” and also the pity glance the teacher threw at me “Don’t you want something more fun, like a firefighter?” But what

in the world ☺.☺, when are professions supposed to be fun, that is why they are called jobs and not hobbies ☹_☹_☹_/...and so far so good, I have not found medicine to be a misery either (closest antonym of *fun* I could find).

In fact, a profession should not be measured by a “Scale of Fun”. Sure, you may enjoy what you do and be satisfied with your development (— — —). However, I hardly find it *fun* when you have to say to your patient “I am sorry Mr. Z, but you won’t recover functionality below the waist. We are here to help you to cope with your new lifestyle”. I dare to guess, that it is not *fun* to rescue a severely burned child and hear the screams of pain of the little one while getting them out of their burning house...

Now returning to my first-year eudaimonic^a state. It was during the very first weeks of my first year in medical school: “The first thing you will learn is how to write”. (Weren’t the required 12 Spanish and 12 English credits enough? (- -;)). So, we went the next couple of hours memorizing how to do a CC (chief complaint), HPI (history of present illness), PMHx (past medical history), SHx (social history) and ROS (review of systems). I wanted a refund! (; — —) Twenty-four credits in language: poetry, epic poems, novels, short story...I even made a book, *Amatán*^b, during my

^a Eudaimonic: From eudaimonia which means Happiness or flourishing. For Aristotle, eudaimonia is “the highest good and the end of its own sake”⁵.

^b *Amatán* is a one-print edition with the purpose of defining “yourself” within the cultural, historical and ancestry context. The course aimed to have an application of self-analysis along with social science techniques such as interviews and literature research.

second year for a social science course \(\text{X}^{\text{O}}\text{X}\) . But I have never seen such narratives in my life, unknown to me, medical narrative became in the following years my third language (◦●◡●◦).

Montgomery describes the medical narrative as a medical plot with the purpose of understanding a diagnosis¹. I remember, how my medical narrative was shaped through the three years of medicine. My patient notes included *everything*, most of it classified as “junk” information to determine the diagnosis or course of treatment(¬¬). “Patient’s dog died yesterday; her mood is sad”. And the resident would point out that it was unnecessary information due that the chief complaint was knee trauma after falling from the bicycle (¬^¬). I remember being more than 30 minutes with a patient, asking about everything (checking the long list) ...preparing for case presentation.

“Good case presentation, but why go into so much detail for sexual history? The patient’s complaint was a sprained ankle” ...(>ლ) All of that is part of the learning process.

In the first year, the students must learn the array of questions. In other words, the list must be known by heart, and the students must be comfortable asking questions that I would not even dream of asking in a social get-together with friends (. _ .). This is known as the comprehensive patient notes (AKA ask everything). Second year aims for the Focus History and Physical Exam. The challenge is with more constrained

time, gather the necessary information for a diagnosis and treatment plan. Therefore, you need to know the extensive list by heart (■■~■■), but also how to apply it on a case by case basis. The ultimate challenge is the USMLE Step 2CS (*^*). Gather the information (history and physical exam), provide counseling (i.e. stop smoking, please \(-o-\)/), give your three educated guesses (the diagnosis) and a workup plan. Of course, answer any challenging questions and be sure to build rapport, all of that in 15 minutes or less. Then you have 10 minutes to convey all the encounter's information in the patient's note.

Interesting indeed...adding the unique medical narrative's structure along with the medical jargon, medicine become pretty much a language on its own (☹☹). A very formal and structural language, almost achieving 100% objectiveness. Yet, the patient's story is missing, as stated by Anthony Moore². A clear example I can think of is with my bioethics master's degree director, Dr. Travis Rieder and his book *In Pain*. Probably, I could recreate a medical narrative that will be, more or less, similar to the original note. It would start with something such as *Case of a 33 years old male that presents to the ER after an MVA with a degloving injury with open fracture of his left foot...* However, if you read at least the first five chapters, there is much more narrative conveyed from the patient's perspective.

Should we make physicians gather this information as well, and incorporate all of it in the patient's note? ☐ (^ • _ • `) ☐ Not likely, the time constraints and the patient-physician ratio in the healthcare system (especially in a trauma unit) would not make such an endeavor feasible. Still, physicians *should be aware* that there is a story behind every patient ☐ (. ' _ ' .) ☐. There is always a slipped comment where someone on the floor said "Oh, did you check the ~~[one with]~~ broken pelvis?" or "The migraine one is presenting with fever now". I cringed, still do. I felt, and pardon my comparison, (>ლ) like when I bicker with my siblings over the phone after buying chicken in our favorite fast food chain. "Yeah, I got two thighs, two drumstick, one breast...and obviously the wings...sure I will stop by and get the barbecue sauce..." For some odd reason, there is no chicken (whole) but pieces of it (parts).

Before my MBE I would say something like "*Nonetheless, human beings are not chickens, and therefore, they should not be treated as pieces but as a whole*" ≧ ☹ _ ☹ ≦ ...fortunately I got the chance to hit my face over the table (over and over again) during my Global Food Ethics Course given by Dr. Anne Barnhill (who is also my thesis mentor). The previous argument as it is, falls under the Peter Singer's *speciesism*^c. The details are out of the scope, but the point is that animals should be ethically and morally considered; there is no default value just for being non-human.

^c Speciesism is a "prejudice or attitude of bias in favor of the interests of members of one's own species and against those of members of other species" (Singer, 2007) See Appendix.

I remember my rotations at the trauma bay, I even heard compelling stories where an arm arrived before the person... I think that after constant brutal exposure, physicians dissociate the disease with the person as a mechanism of defense; making it perhaps easier to cope with the situation (—_—). Nonetheless, efforts should be made and go beyond treating the “severed arm” and recognize the personhood in our patients. I believe this would provide a better care. It is virtually impossible that the healthcare professionals gathered the information provided in five chapter of the book *In Pain*, without increasing mortality (^_^);. However, physicians should be able to treat the patient and not patient’s pieces; by recognizing that each one has a story behind them (~_^).

Most of the physician’s experience is acquired through the empirical training (r_■_■), rather than reading books. I have known the SPIKES^d mnemonic since the second half of first year. However, it wasn’t until my third year when I was exposed to Bad News Delivering by the residents and attending in a family meeting; or when I partially participated in telling my patient that the colon biopsy returned positive for adenocarcinoma under my resident supervision, that the SPIKES burned into my memory (>_<). Which also proved to be problematic as will be seen in Part II. In the book *In Pain*, a pendulum analogy is contrasted with the opioid epidemic response-

^d SPIKES (Setting, Perception, Invitation, Knowledge, Emotions, Strategy/Summary) is a six-step protocol for delivering bad news (Baile et.al, 2000) See Appendix.

history; swinging between unstirred restriction to unhindered freedom³. I will borrow the pendulum analogy for a second, it is good to have guidelines, but I assure you that you don't want the conversation to go strictly, step-by-step, word-per-word...it is very robotic (☹_☹). At the same time, you want to have a sense of uniformity in the profession, because too much creativity is an invitation to chaos as well.

Enough of Part II spoilers (n_n). Narrative medicine provides a learning tool for students and clinicians regarding these personal experiences. If the narrative is attached to critical reflection, then the healthcare community can learn about struggles and mistakes that may be faced in similar cases. So far, we have discussed two narratives: the medical note and the medical encounter through a patient's perspective.

The latter along with medical narrative promotes reflection regarding the humanitarian components expected from the profession such as: empathy and compassion⁴. Masterpieces such as *The Use of Force* by William Carlos Williams, *Brute* by Richard Selzer, among others, provide an insight in the physician-patient relationship that the expected medical note cannot convey: feelings, thoughts, attitudes, and beliefs that are not and cannot be shared through the structured medical communication.

Let's pause for brief moment. By no means I am suggesting that physicians' feelings, thoughts, attitudes, and beliefs should be fixed in the patient's note. Can you imagine seeing around 50 patients' consult, where some may have life-threatening

situations (@_@) and then you have to read through whether your colleague felt satisfaction, but then regretted it, by forcing a patient through a procedure, for all the 50 patients?! (>_<) Burn out would be an understatement!!! (x_x) However, as an educational tool, it has unconceivable value ♥_♥. After reading, Williams and Selzer's short stories and then working in a reflective critical analysis, guided by Dr. Jeremy Sugarman and Dr. Lakshmi Krishnan; I gathered experience that perhaps I would have not gathered throughout my entire career (i.e. the setting for an encounter, specialty, different population, etc.).

Still, I believe that another text could be added (. ' _ '.) r. Since my first year of medical school, I have been writing what I called "*Mini-Reflexiones*" (Mini-Reflections in Spanish) of the different encounters I had lived. I love to write (I have a few unpublished fictional short stories and two novels; and during the early teens a few fanfictions [*Yeah, I know, I am such a nerd (^o-)*]). Therefore, I gave no thought of the mini-narrative beyond as an extension of my hobby, and an escape valve under the high-pressure environment (>>.<<). It wasn't until my Bioethics Practicum mentor, Dr. Joseph Carrese, suggested that I worked in an ethical-medical narrative for my writing component. A reflective compilation from an MD/MBE student's perspective, whose third-year clerkship occurred simultaneously to Hurricane María's devastation. The Practicum's proposal was submitted to the program and the project was accepted \ (°'—'°) /.

Metamorphosis: It is Selfie Time

Chapter 2

When composing the official petition for the amendment for the writing component of the practicum, I knew the important role that narrative medicine played in ethics. The question was what role, if any, could my narration play...I was not an MD nor an MBE...then why...which contribution could it make? *No, I was not having a self-worth crisis* (¬ o ¬) Very ambitious, I did not want to merely have my Practicum done, I wanted to try and do something else. And I also knew that my mentors expect much from their students (^o^). So, I just sat down and started to think about the Mini-Reflection, what compelled me to write them? After some time, everything came in a rush (>>.<<): *“Will I still remember the feelings, the impressions, my thoughts, the formulation, my worries and fears, my dreams and goals? Would I remember how my diet changed for two days to almost nothingness when I was presented with my assigned cadaver? And then how annoyed I was, after a few months, when I needed to eat my snack outside the anatomy lab, instead of eating my granola bar with one hand and studying the heart with the other. Will I*

remember, how my family had to scorn me to keep my thought to myself when I recognized a vein or a bony feature in my chicken (and to refrain myself from rebuilding the bone anatomy)?”

Setting aside my near table banishment due to my newfound manners during and after my Anatomy lab (ଫୁ...ଫୁ); I was afraid to forget what it felt like... I was afraid of desensitization. At the beginning I was skeptical of people and at some point, annoyed when telling them I was going to become a physician. It did not matter whether I asked for a letter of recommendation or if someone innocently asked what the future awaited me, the moment they knew it was Med School, it was the moment where comments went downhill: *“You will hear about moral distress and it will change you”* (Whaa? What distress in morality? What in the world is that?); *“Don’t turn into a robot”* (o__o); *“Money and fame destroy doctors...”* (Uh, if anyone knows a profession immune to this, please?) *“Don’t transform and never forget who you are”* (Risk to amnesia and mutations apparently, sweet! (-__-)). Really?! Did people tell other students (such as engineering, business, etc.) the same litany? ଓ_ଓ. Apparently, my desensitization fear was hysterically shared by the population...the real question is why? Through the years my annoyingness, turned into genuine curiosity. There must be something that the overall population is noticing within the medical profession. It would be like society is trying to mitigate whatever change physicians endure by appealing previously to the metamorphosis. Highly speculative, but worth mentioning and analyzing “_(\’\’)_”.

Through the years, I learned that first desensitization and forgetfulness were not the same; and second desensitization is not wrong in itself. Desensitization is in fact needed; the challenge is how much is needed (@o@). The best example is Aristotle's Doctrine of the Mean, where an intermediate condition is better than an extreme⁵. According to Aristotle, courage is considered a virtue because it is the mean between the vice of defect (cowardliness) and the vice of excess (rashness)⁵. The same could be applied to "correct-sensitization", the defect-vice would yield over-sensitive doctors, while the excess-vice would yield apathetic doctors. Both extremes render the physician utterly useless during a clinical interaction (>_<). The patient is searching for support during difficult situations, it would be problematic if the patient needs to console their physician when they reveal a positive biopsy for cancer (o_O). And it would be equally detrimental if the physician were to be completely desensitized to the point of indifference (O_O)/.

So, what about the forgetfulness issue? (¬ o¬) Well, they are not exclusive of medicine, that is why people have diaries (my first official diary was in fifth grade). Practically, this could apply to anything: puberty, high school, undergraduate, getting your driving license (^o^-)/. Yet, there is something mystical with medicine. Re-reading my reflective writing regarding the anatomy lab, made me revive the moment more vividly, there were details concealed at the back of my mind...it was easier to wallow in the raw feelings and memories. What I mean by this is that for example, I do remember

having very good, pleasant and peaceful times when I was 3-4 years old (I cannot vouch for my mother's agreement on this (;-;)). However, I cannot remember the details...the raw feelings day per day basis. It feels like if the brain consolidated memories and transformed them into experiences that had shaped me to what I am today (@_@). I think the same happens with the physician's training.

After the in-depth analysis, the concept became clear. Anthony Moore regarded the patient's story as the missing medical text². What about the medical student story? (°.°). If a physician is a butterfly, the medical student/resident a chrysalid and the pre-medical student a caterpillar(°o°)...Does it mean that a butterfly is no longer a caterpillar, are the stages mutually exclusive? I *remember* my first patient note (@.@) and I wonder what I would think after 20 years of practice of my current notes. Thus, is the medical student story the *forgotten text* or will my caterpillar and chrysalid state prevail or a merge of all the stages altogether? (= _ =) How will it affect the medical text; does it affect beyond the esthetic of the correct structure of the patient's note? The purpose of this narrative is to try and trace the pathway between the caterpillar to the butterfly transformation (❤o❤). Although, experience and interpretation cannot be extrapolated nor generalized to other medical students, it may add insight in the medical education and physician formation. So, let's get started: It is Selfie Time! \(*o*)/

"First year is adaptation, second year is madness, but the third is glorious..." – that is what my upper classmate said in 2017. I was a second-year medical student back then

(^o^). The school required specific visit for MS2^e to the hospital for assigned cases. I agreed with the first two claims and I wishfully yearned that the third claim was true (´_´). I swore that if anyone talked to me about a disease or a pharmacological adverse effect outside study time (virtually zero) (¬o¬) I would explode. Unfortunately, I was at the point where I could not unsee things: rashes, gaits, for the love of (~_~), even the types of coughs...it was becoming a second nature just to see everything medically. Moreover, the Step 1 was next door \((OoO)/...I was just plainly tired and wanted to believe, that the next year could not be any worse. Right? (o__o) Sincerely, I did not pay much attention (u^u), it wasn't until the third year that I was dismayed with the third claim.

Third year was enjoyable (as weird as it may sound) (-;-). I was finally practicing what I wanted to do since high school. The sensation is similar when you are five years old and your parents allows you to run bicycle alone, far away from their range \((OoO)/. And you feel so independent, your chest swells with pride, you are ready for the world outside...and in reality, you are just one house away (#¬.¬)/, plus your parents are sitting in the sidewalk pretending not to look at you, giving you false freedom, a pretty illusion (u_u). Practically this is third year...you have your own patients; you must think of a diagnosis and treatment, you are *THE DOCTOR*...In short, you're in pull-ups (.__.) .

^e MS2 = Medical Student; Year 2.

But I still fail to grasp the *Glorious moment*...It is challenging to link the avalanching casualties...a ventilator dependent child (otherwise healthy) that did not reach the hospital on time after a failure of the generator at his home. I failed to see the *glory* in the quiet death of man in the hospital hall prior to even being admitted; noticed by a nurse 24 hours later after his death because he was too still. I failed to see the *glory* in the mad scramble for medication...I was failing miserably, *and still do*, to grasp the “*glorious moment*” through the patient’s suffering.

Could it be that all of my third-year clerkship were affected by Hurricane María’s devastation? I could never forget (... *and I hope I don’t*). Pediatrics was my first clerkship, it started late August-early September...Maria wrecked the island on September 20, 2017. The aftereffect followed throughout the academic year, power supply was partially restored around January at my house (and we were one of the lucky communities). The Internet was unstable for months...Trust me, it sounds very vain (:-/), but I assure you that both the power supply and the Internet were not for the A/C and watching the recent *Anime* episode on *Crunchy Roll*. The learning materials (videos, books, and articles) were required to be purchased as online versions. I never got along with the platform (☹ _ ☹); thus, I bought the paper copy of the core books. Yeap, this is what I call making Med-School more expensive than it already is (~_~). Some of the classmates asked to be waived from the book’s fees, since the platform was hated by a few...but it was a bundle made by the School and there was no way out of it (●.●).

Although, I wished that I would be saying this in other circumstances, the economical effort of duplicating the books in hard copy paid off during the power surge⁽ⁿ⁻ⁿ⁾. For me the adaptation challenge (regarding acquiring academic material) was during the second clerkship: Surgery. There was a yearning of returning to normality, it all seemed like a bad joke. I learned to study at the rooftop, at the garden (^_^)...I learned to cross my finger for the sake of my mother and grandmother when I had to turn on the generator at immoral hours in the mornings(>>.<<). The third, fourth and fifth rotation were schedule for January 2018 until May 2018: Ob-Gyn, Internal Medicine and Psychiatric, respectively.

Nonetheless, even if Hurricane María had not happened, should I have felt *glorious* in our success? Where are we; ancient Rome? \(-^-\)/ Isn't the dedication, the responsibility owed to patients expected from our profession? How can our duty – regardless of the “outcome's success”- be classified *glorious*, like some sort of divinity(•_•)...It is not like if I had been bestowed with supreme healing powers. Again, do other professions have this confounding factor? Do lawyers feel that they have supreme powers of justice? (o_O) Is an accountant afflicted sometimes with the deity-disease? (°_°)

In fact, sometimes I have felt ashamed of myself, overpowered. We were doing our best...but sometimes it felt that it wasn't enough, seeing the patients and their family in pain and feeling that [in some cases] they blamed the team for the tragedy, for not

“doing enough”, for “letting them die” ... It is a dance between life and death. It is a science and art, but at least this caterpillar-chrysalid had not felt the demi-god upgrade(¬_¬), and it is something I am not looking forward to(¬.¬). Nevertheless, I have encountered one moment that chilled me. I found myself one time, alienated of “me” ...was I losing myself in the process?

It happened during the Internal Medicine rotation. After conquering the barrage of medical question list given for first years, a log was assigned. A series of diagnoses were given at the beginning of each rotation(n_n), we were required by the end of the rotation, to have the signature of our senior resident or attending, confirming that we were exposed to the required diagnosis. No pressure at all it was a type of measurement for diagnosis diversity(^o^)... sanctions could range from poor grading, a note in your record or just failing the clerkship (—_—;). Therefore, everyone had to scout and stalk diagnoses(O_O)/...there was one time that I was so content “YEEEEESSSSSS!!!!!! I found a renal failure, hypertension and anemic patient!!! Three in one!!!!”. I was so overjoyed!!!!...

I decelerated, almost coming to a stop. “What have I just though? Was I just smiling, was I just happy?” I still remember the heavy feeling in my chest. Who in their right mind find this exciting or a subject for celebration? \(\^o^\^)/ You don’t need to be a physician to know that this patient was enduring a very poor prognosis, he along with his family. I entered the resident-student lounge and gave my diagnosis log.

“Oh, is this Mr. A?” – asked my resident while signing the three dreadful diagnosis.

“Yes.” – I answered politely, my mind was galloping. I needed to write my patients note, *his* patient-note. And I urgently needed to know what happened with me a few minutes ago.

“Since cases can be repeated in this clerkship, I suggest that you all visit Mr. A.” – our resident told the rest of MS3. “He has hypertension, anemia, renal failure, you [referring to me] already had signed the diabetic diagnosis, but he also has diabetes”.

“Great! Four in one!” – cheered my fellows MS3 and scrambled toward Mr. A. room. I sat down in a corner to write my notes and check my assigned patients’ labs...but I urgently, needed time to think. What other changes were subconsciously happening? (*^*) I was not liking where my chrysalid was going...Is this the person I wanted to become? Would I be proud every time I looked at myself in the mirror? When did my *pure golden goals* of medicine exchange for filling a retrograde log (¬.¬)?

This was my fourth clerkship and I was stepping in dangerous water; I was close to the excess vice of desensitization(>_<). Since then, I inwardly cursed to the pressure and importance given to the diagnostic log. Our clinical time was cut off by a week and depending on the location of your rotation you may never be exposed to certain populations (-__-). Of course, the experience is essential, but other substitute methods should be available. The “worship and devotion log” \(\text{x}^{\text{o}}\text{x})/ approach is detrimental for one rotation [at least under the state of emergency circumstances], but it is devastating to encourage it through all five clerkships. As a student you have clinical duties (which

mostly takes most of the day) but you also have academic duties. Many times, I had to stay close by the hospital while studying for the rotation killer test or writing assigned long cases in order to complete the dreadful log (¬_¬). What was this *Pokémon*^f? \(-^-\)/. *Exasperation*. That is a good one-word description. I remember one colleague saying, “I always want to finish with the log and then concentrate in medicine”. Funny, we were perceiving our duty as students as mutually exclusive with medicine (@_@) .

Unfortunately, that wasn't my first time, I found myself slipping a few more times when I found a very rare diagnosis...but I never reached the same height of happiness. I checked myself, until I weaned from the toxic learned behavior...I did not sign up in medicine to fill, mindlessly, diagnostic logs \(-o-\)/ ...I had a reason, and that reason was not interchangeable. Mind you (u^u), that there is also certain Oath and Code, that would be less than content with *Pokémon Master* overachiever approach (¬ o ¬) .

^f Pokémon is an animated TV series (and also a franchise such as games). One of the characteristic features is the importance of capturing strong and rare creatures called Pokémon, in order to win battles and/or contests.

Professionalism— Clinical Ethics Teaching Session

Chapter 3

“What does Professionalism mean?” Stopping for a second to think about it, I realized that at least I knew what "unprofessional" meant...not likely (‘— ◇ —’). My brain was confabulating to fill in the gap (:~p). If it was so hard to define professionalism, then there is a high probability that the notion of being "unprofessional" is also unknown to me. Currently, I am a 75% MD (Completed 3 out of 4 years) and had completed my third term of my bioethics master's degree. And yet I was struggling how to formulate a strong and concrete definition for professionalism\(^{oo}\)/.

The *Clinical Ethics Teaching* session was designed for second year medical student. A brief introduction made by two internal medicine physicians (Dr. Joseph Carrese and Dr. Zack Berger), followed by case presentation, small group discussion and then sharing the discussion with the rest of the class. No laptops, no phones...just

one power point presentation and grey matter power $(^o^)*$. The AAMC, LCME and Charter on Professionalism provides the definition of professionalism. However, the first activity of the day, Brainstorming, provided a more global and tangible conception of the term $(\neg.-)$. “A professional” was described as a respectful towards the patients and colleagues, competent on their assigned skill, honest, humble by knowing their limitations. At the same time, it was helpful to define unprofessional and it was described by the second-year medical students as being dishonest, engaging with physical and verbal aggression, among others.

It was concluded after the brainstorm activity that Medicine is the balance between privilege and obligation, as well as, public trust committed to self-government. If the profession’s goal is to prepare trainees for unsupervised practice, then professionalism preparation is a must. The importance of wellness and resiliency were briefly discussed before starting the first case.

Case 1

A student had made 2 lumbar punctures (LP) supervised by the resident. A third patient a 68 years old man presents to the hospital with fever, nuchal rigidity and disorientation, an LP is indicated. The Resident says to the student that he cannot supervise the LP, because he is with another patient, unless it is after 4:00pm. The student’s rotation ends at 4:00pm. The resident gives the option to the student of doing the LP by himself or to call the intern from the ED.

What is (are) the problem(s) with professionalism?

As medical students we have a duty to learn, but we don't have the set of skills (competency) to realize them. Also, the student may feel pressured for a good evaluation from the resident and show that he is a good team player. The other problem is that there is an obligation to the patient that needs to be correctly diagnosed and treated for a life-threatening disease. Like any other procedure LP has risks and complications. Furthermore, an error (i.e. sample contamination) could delay a more accurate treatment for the patient.

Ethically speaking: The student's duty to learn and their responsibility to achieve the professional milestone (evidenced by the evaluations) are in conflict with the principle of non-maleficence. The principle, treated as the maxim, *primum non nocere*, "obligates the individual to abstain from causing harm to others"⁹. Moreover, *professionalism* is in question also. One of the discussed requirements is to possess competency. Are two LPs enough to acquired competency? Would the benefit of having an earlier LP with a less competent trainee outweigh not having an early LP at all? These deliver us to the following questions:

What are the options? What are the tradeoffs?

One of the options is to wait after 4:00pm, assuming that the student does not have any other academic obligation (i.e. conference, test) and that the delaying of the procedure would not cause more harm (i.e. It is 3:55pm and a five minutes delay would

not make a difference versus if it is 12:00pm). The tradeoff is that the student may feel like they are not helping the team or making a good impression, and the patient is waiting more time.

The second option is that the student informs that he does not feel ready to make an LP alone. The intern would be pulled up from the ED and the patient will have a sooner and more accurate diagnosis. The tradeoffs are that the student may feel like a weight on the team since he could not alleviate the workload from his superior and have distress regarding making a good impression on the team. Also, the student could lose the learning opportunity of making his 3rd LP. An alternative option would be to ask the intern to supervise the student, but it would all depend on the workflow at the time.

The third option is that the student asks a nurse for supervision or to actually make the LP unsupervised. The tradeoff is that this goes against policies and to some extent safety. Two LPs are not enough to be competent and even if the student made 100 LPs, he still does not have medical license or have all the necessary skills to be left unsupervised by another licensed physician. The tradeoffs are patient and student's safety. This option was the least popular during the group discussion, and I agree.

I would like to add, that besides the "end-my-world-dilemma" (AKA Performance Evaluation), there is another pressure that haunts the students "What if I harm my patient, what if I kill my patient?" These are the questions that makes your

heartbeat goes faster, when you are walking down the hallway, rehearsing every word and action before arriving to your patient's room (it helps you with the compulsion, but it never works). However, there is one situation that I know that the third option becomes a necessity...when a disaster strikes.

Puerto Rico has one tertiary hospital at the capital, and it is also the home of the only public medical school in the country. After the Hurricane, we were quickly saturated...communications and electrical power were down, peripheral hospitals could not open for service or did not had the resource to keep their patients. Allocating resources was a challenge, this included power plugs for ventilators, but also human resources were not enough. Nurses, residents, and interns were already saturated, third year and fourth year medical students had tasks that perhaps during a normal year we would not dream of having. Granted, we did not perform appendectomies or deliver babies alone(o_O), but I had many experiences that made my heartbeat increase. The saturation condition lasted pretty much the whole year, but the hospital condition got better, baby steps, but better, nonetheless.

"Did you see the videos for ABGs (arterial blood gas)?"- inquired my resident, the team was working non-stop.

"Yeah." - I was not liking where the conversation was going(• _ • ;). The team had patients scheduled for surgery, inpatient floor was full, internal medicine and the emergency department did not stop asking for consults.

Deep down, I knew that she could care less in that moment whether I could watch the video or not(-.-;). In fact, I did watch the blasted video around 1:00am in the morning(¬o¬), we had to report at 4:00am (optional it was open to arrive at 6:00am), no exit hour scheduled. I remembered the details of the videos and also the complex ritual (-__-) of turning on the generator plant at that hour, crossed my finger for any curse against my mother...at that hour not a lot of people were using the internet (obviously) (ಠ_ಠ) / and you could see all the videos that you wanted, at a snail pace(¬.¬), but still watch them.

"Take one ABG kit, and get the sample from L.X., room 16"

"What if I get it wrong?"

"You won't, and he is on nasal cannula"- and she waltzed away, going to a patient that the intensive care unit paged.... Cold bucket (x.x). I was still uneasy, thoughts came rushing. *Yeah, he was on nasal cannula (Was that supposed to make me feel better? (•_•)), wonder why do we need to do an ABG... and, and, and why did I waste my time at an amphitheater, med school should be delivered by video (¬.¬).* Practically I got a good 15 seconds of rambling and ranting in my mind. However, at the same time, I had to do everything I could to help out, it felt like everything was falling apart \ (xox) /, and we needed to keep it all together...but at the same time I wanted to be cautious that my "super hero delirium" did not get out of hand (@_@)...*the road to hell is paved with good*

intentions. I stood there a few seconds debating the course of action...To the Counter!

\(^o^o)/

I asked a nurse if she could come with me, and in less than 1 minute I gave her the case. "*A desperate third year medical student presents for her rotation 5 hours ago...*" and you can imagine the rest. Under the nurse instructions, I successfully drew the ABGs, placed them in the bag with ice, thanked the nurse (who took her time from her non-end shores) and delivered it myself to the lab(^o-). Yeap, medical students functioned as cart, escort, or material seekers. *Can relate to 'Indiana Jones's adventures*. I did not explicitly disclose to L.X. that he was my first ABG attempt. But I did tell him that I was a third-year medical student (that is how we are told to present ourselves), and the short coat gives it away as well. However, if he were directly to ask, I would have told him in heartbeat that he would be my first ABG... I believe we did the correct thing, the question that I ask myself now is how much does the rule bend under a crisis? (~_~)I think that medicine is a constantly weighing benefit-risk, and the circumstances play an interesting weight in the balance...

What ought to be done? Why?

The answer to this question, is simple and short. It also was my most hated and awe-striking answer during my first term at JHSPH (currently I am accustomed to it): "**it all depends**". (J^o^o) I must confess, it took me two terms to understand the answer \(^xO^x)/. Sorry *first-term-me*, you would surely hate *third-term-me*, but this question is

answered with an "it all depends" ￣_(ツ)_/￣. Medical ethics depends highly on the facts, depending on the theories or methods used to analyze the case. The same outcome could potentially be classified as right or wrong...some theories are even sensitive to the motivation behind the action. So yeah, a painful journey indeed (￣■_■), to understand that most of the important and crucial questions in life are answered with **"it all depends"**.

If I were placed in the same situations and the resident told me that after 4:00pm she could supervise me, and it was 3:50pm and a 10 minutes delay would not pose a risk, it is most likely (almost 99.9%) that I would have waited for the supervision(*_*) . Who would reject the opportunity to gain the experience of their first ABGs? \^(oo^)/ On the other hand, if the same scenario repeated itself, I would, again, walk to my haven...To the Counter!

Case 2

A 73 y/o white male presents to the ED due to a COPD exacerbation. Twenty-four hours after admission, the team visit the patient during rounds. The patient informs the attending physician that he does not want a -pejorative racial insult- as his doctor (the resident) and points to a medical student (unknown to him) as his preference.

What is (are) the problem(s) with professionalism?

Here is a big issue, a patient that is refusing treatment due to racism. Definitely, a crack in the physician-patient relationship has been made. Furthermore, the physician

has the upper hand, the patient is ill and vulnerable. At the same time, physicians are humans who deserve the application of the ethical principles as well, like for example, respect for persons (—.—). The question is how to deliver optimal care when the patient is rebuffing treatment due to discriminatory behavior. How to deliver optimal care when physician may feel threatened?

My third year Psychiatric (Psych) Clerkship consisted of 1-week conference and 3-weeks on the field. Even though it was my last clerkship, I felt equally lost in the inpatient ward. And this is interesting, sure you may see a depressed or sad patient from now and then, but for some reason there is a separation between body health and mental health (@_@). An example is how some believe that to assess a patient's capacity we need a psychiatrist to do it, even [for some physicians] the capacity context is foreign with medicine. Nonetheless, at the end of the rotation I felt more confident in dealing with mental health diseases especially suicidal, bipolar, depressive, and schizophrenic patients. Also, it gave me insight of the seriousness and reality of mental health disease.

Returning to the main point of our case problem, a resident was teaching us the Safety 101 during the first week. One safety technique evoked an open-mouthed, stupefied reaction: The Biting-Maneuver (o_O). *I surely hope it was not expected on my log, right (¬ o¬)?*

"If a patient bit you, you cannot pull because you will tear your skin." True, very logical, I was nodding inside my head. And then what? \(\text{XO}\)/ Do we Jackie-Chan-poke their eyes, it works with shark apparently? (o_O) I just pictured myself in a supermarket or a park, and someone bit me out of nowhere...a ninja-anime-scene played in my head(¬■_■), surely it would be less graceful than what I picture. Her voice returned me to the small classroom.

"You have to move around to where the patient is moving, until someone close by gives him the "triplet" (Haldol, lorazepam, and a benztropine or diphenhydramine). That is when I realized what I was wearing...my short white coat, yeap as Uncle Ben said to Peter "With powers comes responsibility" (or something on those lines (¬.¬)). People were more concerned, me turning into a *Wall-E*, and nobody told me about biting-maneuver risk...*Where do I place this on my CV* (¬_¬)?

After my first brain was fatigued, it was time for the second brain (the one with reasons to kick in)[§]. They are vulnerable patients, they came searching for help... (and I surely did not sign up to be bitten(¬o¬)), however, those are the risks of the profession and we are free to quit at any moment. The question is how should we act? How can we protect ourselves? (@_@)Physicians (and students) are humans, we have emotions, bad days, etc. A healthy working environment avoids emotional and moral burnout, and

[§] During my first term we discussed Dr. Daniel Kahneman thesis (found in his book *Thinking, Fast and Slow*) between two mode of thought: The fast brain (System 1) which is driven by instinct and emotions and the slow brain (System 2) which is the rational and logical.

avoiding burnout increases the chances of a better service to the overall patient population. Definitely, these issues must be addressed but in a very orderly manner, we are not in the kickboxing field (although sometimes it may look like it (¬_¬)).

Yet, this is very different, unlike my previous experience, this new patient population has their mental health compromised. *This is an example of the innocent separation between mental and body health. This was not a thought I had transitioning from Pediatrics to Surgery. However, I have a hunch of why this distinction is important...* Most of the patient population during Psych rotation have their capacity and autonomy restricted and/or compromised. Therefore, issues such as decision making, patient's best interest, honoring patient's values could be more challenging than in other professions. Furthermore, the chances of treating patients with the "expected" inhibitions (aggression against others and themselves, sexual constraint) and unbalanced intense emotions (fear, sadness, confidence) are higher than in any other specialty.

But then again, what can we as physician do to provide safety, not only to the patient, but also to the working staff? Acquiring the Biting-Maneuver ~~technique~~ *awareness*^h is an example of how physician mitigate the risk of the profession: through

^h I am proud that I avoided any biting-accident, but I am not comfortable saying that I have the technique mastered...and I don't think it would be ethical to implement a practical component at Med-School...Can't imagine "Mortal-Biting!!! Fight!" (Those who had played *Mortal Kombat* understand this reference).

training and protocols. There is an effort to foresee the risks, and also provide a solution, such as the Biting-Maneuver-Technique. However, bigotry, which is a potential threat, was not discussed much (I don't recall (@o@)). It could be due that culturally there is a resistance to thinking that there is bigotry at all in the island. I recall that during one of my Social Science courses when doing my bachelor's degree, there was sometimes resistance to acknowledge, that like any other place in the world, Puerto Rico was not exempt of prejudice^(x.x). Obviously, Case 2 manifested during the wards, but more important was the response.

What are the options? What are the tradeoffs?

Interestingly, there were mixed reviews. Some argued that nothing must be said at the moment, others that the attending physician should confront the patient, and others asked regarding the patient's mental status. Doing nothing would promote this type of behavior in future occasion, and with nearby patients that may be observing the situation. Furthermore, it would create discomfort on the team. I remember an article written by Jennifer Adaeze Okwerekwuthis in 2016⁶. It arrived in my email under one of my medical association newsletters. Adaeze explains how a patient referred to her as "colored girl", and how she felt when the attending physician did not address it with patient or privately with her⁶. A sense of abandonment can be perceived during Adaeze's narrative.

The other option offered (and I agree with this one) is to address the situation at the moment. Surely, there are array of methods to do this^(u.u). We wouldn't endorse (nor expect) that the physician responded to the bigotry, like they would to a "honking-car" while changing from a slow lane to a high-speed lane, during their late teens (very colorful scenario) (¬.—). Instead, a boundary of respect should be placed. The options include the intern's reply right away, the senior immediate reply (fellow, senior resident, attending), intern report to the superior, the attending address the matter at a later time, etc.

I think that the intern should not answer right away if they don't feel comfortable. However, I do believe that they should observe how the superior addresses the situation, with the goal to acquire the competency in such situation (crossing our fingers that the superior does not respond with the "honking-car" approach).

We [the second-year medical students and I] were curious of what is the average outcome when a patient is confronted...and it is pretty much diversified. Some asks for forgiveness and refrain from racist behavior at the hospital, others say a half-heartedly "sorry" and continue with their behavior, others couldn't care less. Depending on the severity of the case, the hospital may administratively discharge the patient. This conversation made my mind travel back in time.

I was in charge (㊤(ò_ó`㊤) ("pull-up version in charge") with a charming elderly man, he had a valve replacement, and the team was trying to anticoagulant him. Yet his diabetes was keeping the heparin on his skin. We were worried about clotting and potential stroke. My task was to have the daily progress note (。●_●。) (AKA history and checking his heart sound) ...it sounded different, a little bit mechanic (or perhaps it was my imagination playing games) . MS3s tend to have awful auditory skills(>>.<<), we hear things that are not there, and do not hear the things that are there; truly fascinating phenomena (@o@).

A few hours later, we did the morning rounds with the cardiology fellow. When we entered, the patient's first words were "Finally, a 'jincho' (which means a "white" person in Puerto Rico) (°.°). The room fell completely silent... The complexity of race is beyond my imagination and even elicits fascination... Puerto Ricans have their own racial system: Coffee with milk skin color, light honey chocolate skin color (and so on) but the winner is the coffee with peroxide skin color classification (O_O). Don't have any reference of how any of those actually should look like, and I don't plan in a near future mixing peroxide with coffee (☹☹). In fact, I regret inquiring more, about how in the world, the individual reached that classification (= _ =). Now it gets more complicated... After "successfully" classifying the skin color against the type of coffee bean and the soy-milk grade, plus the factorial's ratios of *milk:peroxide:coffee*; then the afflicted souls can start with the hair, nose and lip classification (•_•).

Definitely, this shows the inner complexity of race/ethnicity classification in the island; even though when asked at first, virtually everyone denies any type of prejudice(o_O). I believe that is why they added the *Puerto Rican* classification in the census or when people simply identified themselves as “satos” (Spanish for mixed breed”, whatever that means. Now I feel in the *Harry Potter*-verse, pure-wizards against muggles...the compulsion to place people inside boxes...taxonomy is a blissⁱ (¬ o¬).

Anyway, I digressed, the point was that the patient made a racist comment, and there were plenty of people in the room that were...well, just Puerto Rican \((O_oO)/\). After a few seconds in the deafening silence, the fellow addressed him:

"But what is that expression Don H.? Everyone here is a doctor, what does skin color have to do?" His face turned different shades of red, he remained silent.

"Let me check your heart."- said the fellow reaching his stethoscope.

I felt sorry for him, here he was at a high risk of dying or at best, become a crippled due to a foreseeable stroke. Instead of worrying of how to get better or formulating an advanced directive or making a will... here he was with an imaginary color-shade card classifying healthcare professionals. I felt very sorry...perhaps in two minutes, or in a few hours his brain function could be compromised...It already happened to one of my patients a few weeks early in another ward, but that case is a

ⁱ My undergraduate major was on Cellular Molecular Biology, however, few classes (aka General Biology, Ecology, Zoology and Evolution) required the taxonomical knowledge, from Domain to Specie. I wonder if that is mirror images of what we attempt in our daily life. Supermarkets, department stores, and so on.

discussion for later. Looking back, I don't know if what I felt was compassion or borderline pity(*^*). Was there even a difference between the two? \(\circ_O)/ Is pity an excessive vice for compassion? In medical school they talk about empathy, compassion, even sympathy...but pity is not mentioned in the bundle. It is not expected from us.

Well, first of all, pity is not considered a moral virtue, it is merely a distressful reaction to another's distress⁷. Although we sometimes use compassion and pity interchangeably; (and even consider pity as Hren's description), they had different meaning for Aristotle. Compassion (*eleos*) describes the pain felt toward those that underserved the bad fortune; whereas, pity is reserved for those that deserve the bad fortune⁸. Regardless of which definition, pity is utterly useless for the medical profession(^{u.u}). Feeling merely distressful is not going to help the situation at all. Deciding whether a patient deserved it or not is even out of the question^j...

I glanced at my residents, they had stern look, the famous physician-poker face, devoid of emotions. I glanced back at the patient, his face was getting his normal coloration, but his expression showed realization and desperation. The cardiology fellow visited him one time during the day, but the "*No-jincho*" team were his main contact point, and he just insulted them and was not praised by the fellow...I think that he felt alone and vulnerable.

^j This will be explored in more detail in Chapter 11: Opioids

He was our last patient; we went to the room to discuss and make some notes. We did not talk about the event. Back then, I felt there was nothing to talk about (= =) ; the issue was already addressed. I also felt that, more important was to find a way of how to deliver the heparin to his circulation, before we had a crippled patient in a matter of hours. I think that the fellow's brief and stern intervention allowed the team to function without incident among colleagues or any other patient during my short inpatient week at the cardiac unit. However, after this teaching session, I think that there should have been a debriefing among team members. It would have made the fellow's intervention more official, and something that did not happen due to chance. It would have been a teaching opportunity for everyone in how to address cases of bigotry, because surely and unfortunately, this wouldn't be the last time (— —').

What ought to be done? Why?

The conclusion was that definitely the attending must address the situation (or the one with higher rank present) because (1) the higher rank is supposed to have more experience in how to handle these type of cases, (2) it is a learning opportunity for the new trainees to observe the dynamic and how to correctly approach the problem, and (3) it keeps a healthy working environment, avoiding strains between colleagues and other patients.

My Ethical Education at Med-School

Chapter 4

After the second-year clinical teaching session on 02/22/19, I remembered, my very first Ethics class^(x.x). It was scheduled once a month (if I recall correctly). I wanted the Rx for correct decision making, a framework or a series of command that would allow me to pick the correct choice $\sqrt{(-\blacksquare-\blacksquare)}/\flat$. I was in for a big surprise. The first session was about the ethical principles: Autonomy, Beneficence, Justice and Non-maleficence. So far so good ^(u_u). Then, out of nowhere ($\odot_ \odot$), “stuff” like **MORALITY**, **COMMON SENSE** and **MORAL THEORY** slapped everyone in the face. *Weren't they all the same?* $\backslash(o_O)/$ What about religion? (.o.) What was that... DID THEY JUST MENTION **KANT** IN THAT SLIDE?!! $\backslash(^O^)/$ My brain was trying and failing miserably to keep up for two agonizing hours. *Outrageous...* What were they trying to tell us, were they testing photographic memory as well? $\wp\ \wp_ \wp\ \wp$

Most of the class' background came from Natural Science^(-■-■) ...a few of us made “weird stuff” such as having a major in music, or a heavy credit load in social

science (my case) or in humanities. A question was thrown in the middle “*So, is withdrawing a patient from a ventilator right or wrong?*” I was frustrated and tired. Should we be talking about this at 3:00pm until 5:00pm, really? (>>.<<) I have been an hour into the lecture... surely, I could make an educated guess with this question, right? \ (. _ .) Most agreed that it would be a right decision. The professor nodded, but he wasn’t too pleased with our answer (I wouldn’t be either, you cannot answer this without the “it depends- condition” (¬. —)).

“If you pull the plug, will you be killing your patient?” This definitely was not helping my headache (— —’). Obviously, there wasn’t an easy answer.

“Of course not!” – someone exclaimed indignantly from the back seats.

“How come not? You pulled the plug that was keeping him alive?”

“But what if the patient is brain dead? He is dead anyway!” -another ricocheted. Yeap, I was not the only one frustrated (@_@).

“What if he is not? Let’s imagine a patient that is in a grey zone.”

“What if the patient decided not to be in the ventilator?” – I asked. If I was going back to study with massive headache after 5:00pm, I was going down by doing everything in my power to rage my pain center’s wrath \ (^ ^) / .

“Good question. Would you kill your patient they asked you to?” – *Good question indeed, few years later I find myself trying to answer this question in my MBE thesis...the art of foreshadowing is not only limited to literature, apparently (^o^).*

“There is a difference, we would be withdrawing, not inflicting.” - I countered.

“But it is the same result. When you pull the plug, you kill your patient.” - \(-^-\)/ Okay

I drop my mic, the guitar and the drum too. Definitely, the topic was interesting. *I will*

search this information later, when I am not worried about the blasted Anatomy/Embryology

block test plus keeping up to date with our anatomy laboratory\(^o^)/. I remember vowing to

myself something along these lines. Little did I know that this conversation was a

foreshadow of my MBE and my thesis as well.

“What? So, everyone should be on a ventilator indefinitely! Even if they don’t want to!”

– a colleague jumped in. *Go, go team! Let’s try and squeeze a more cheerful message...or at*

least some damage control for migraine (O_O)/.

“It doesn’t matter. Pulling the plug is an action, and the consequence is your patient’s

death.”- (*^^) I needed a break. Here I was, hoping to have **THE TRUTH**, a magic

compass that showed me the correct answer (ㄟ_ㄟ). I debated to myself ordering a

Magic 8 ball ^\(^_o)/-. At least I was sure of something... I felt we were getting nowhere

with this discussion, besides contemplating whether the risk of acetaminophen liver

toxicity was worth the shot(-_-;). The amphitheater fell quiet, I think that everyone

wanted to lock themselves up and continue with the anatomical memorization or go to the anatomy lab and do something useful (._.)(._.).

“Any questions?” – Two minutes left for 5:00pm(@_@).

“So...we should not unplug people?” – someone quietly asked. The moment of truth (••), finally something practical, the question was shaped perfectly \(-o-)/

“You can unplug but be warned that you are killing them, and physician swore to do no harm.”- Now I felt better(ಠ_ಠ), a *marvelous* take home message (•_•). FINALLY, we were free to go! \(^O^)/

This may sound funny to some, but there is no laughing matter. Ethics should not be perceived as something foreign to medicine(°.°). It doesn't matter how much knowledge you can acquired; how much you can apply it in the field. If you don't know the tools of how to navigate through the multiple issues, then there is no point. (~_~). Physicians should feel confident in their decisions, some issues are legal, but the majority of the issues fall in the ethical realm...and the ethical realm is much more than common sense (whatever that is (¬o¬)).

If you think that Ethics, Philosophy and Morality are abstract concepts, common sense is beyond reasoning (o_O). Bioethicists can agree what is autonomy, justice and beneficence. Philosophers can describe Kantian theory and discern from Natural Law, Virtue and Utilitarian theory. But I would gladly sit down with someone that can

explain to me common sense and how to use it (•_•) (•_•). The closest “common sense” in ethics that I have encountered, is when we say that an action should be permissible if a reasonable person would do it. I bet the little philosopher in you is asking...well what is a reasonable person? \(-o-)/ I will just present a brief case for your imagination: Justify a decision based in common sense regarding blood transfusion. For simplification consider the common sense (based in common knowledge) of two people only: a Jehovah’s witness and a non-Jehovah’s witness...

Frustration. I did not understand this class until my MBE (@_@). It was a mixture of a three-minute thesis competition about the biomedical principle, followed by a convergence between the moral theories and common sense and the grand closure of Ben Bronner causing as *doing vs causing as difference* theory (.-.). The problem is that all of these play a part in medical ethics, but there is no way that all the information could be hammered into a two-hour course, filled with brain-drained students (>_<)/. For starters, the biomedical principles are explained in a whole book by Beauchamp and Childress. One slide per principle titled slamming AUTONOMY, BENEFICENCE, JUSTICE into the students’ retinas (;-;) are not enough to convey the logic and explanation backing up each principle \(\o_O)/.

Second, the moral theories, such as: Kant, Utilitarianism, Natural Law, and Virtue Ethics are philosophical courses on their own (o_O). Furthermore, the high-level theories have been at each other’s throats for a few millennia, (ʘ^˘) seeking the capital

Truth. A whole course was dedicated to the introduction of the theories, which my cohort navigated with an expert in the topic: a *philosopher* in the MBE. Each have their particular strength and weakness, and even if they influence our daily life decision; they are not what physicians or ethical committee focus on. ENTER (drumroll), \((-^{\wedge})/ The Biomedical principles! Which are mid-levels (Between the high moral theory and the low casuistry). Regardless of your preferred moral theory $(^{\wedge}o^{\wedge})$, the Common Morality, where the principles are derived from, neutralize the high order Moral Theory and allows an agreement in the rightness⁹. Consider the following example:

Mrs. B is a 68 years old female who presented to her primary physician with weight loss, iron deficiency anemia and rectal bleeding. She came to her follow up visit to know her biopsy results and coordinate the next steps in her treatment. When asked how she is, Mrs. B replies that she is worried, but she knows that everything is fine, and that her mind is on the next weekend where she would celebrate her grandchildren's birthday in a 7-day cruise. "It is going to be great! It has been a long time since everyone could be together, doctor; my kids have very busy lives".

If the results came back negative, we wouldn't be discussing this $(^{\wedge}o^-)$. The question is should the physician tell her that she has advanced colon cancer, or should he lie? And there are many layers of lying or withholding information; from telling that the biopsy was negative to having a delay in the biopsy results. The Utilitarian theory would favor a non-disclosure approach, if and only if, it would maximize Mrs. B's

benefits (she is 68 years old and this may be her last happy moment with her whole family). Meanwhile, Kantian theory completely forbids lying...What do we do?

$\neg(\bullet_ \bullet)$ Kantians physicians blurt out the crude truth, while Utilitarian's physician hides the truth. And for those that had not bought a theory yet, can buy a *Magic 8 ball* $(\neg o \neg)$. Sounds awful, right? Medicine requires going beyond the moral theory impasse (physician's treatment should be standardized as much as possible for everyone).

So, what do we do now? Do we wait another 2,000 years and see if Philosophy deciphers which theory delivers the Truth? $\neg(\odot \wedge \odot) \neg$ Should we require a *Magic 8 ball*? $(_ _)$ There is another established approach: Casuistry. In short, this technique is used in law, and the justification for an action comes from previous similar cases. Again, it has its advantage and disadvantage $(\neg _ \neg)$. Yet, this is not very functional to implement to cases as an everyday practice, Medicine does not have their own Supreme Court to revise all the cases, compare and determine the correct course of action. Thus, the Common Morality, which provides the mid-level principle, is more feasible for biomedical practice⁹. The catch is that physicians must learn specification and balancing techniques among the principles (which is no easy feat) (^n_n) .

Lastly, comparing withdrawing of treatment vs inflicting direct harm...this is a complex topic to be thrown at the first day of class $(@_@)$. It took me three terms, and a lot of my master mentor's aid (who is a philosopher) to understand Bronner's

argument^k. As stated previously, appealing to common sense is a leap of faith approach, especially for a novice in the field. I have shown how different a conclusion may be reached by using moral theories, which are structured philosophies^(u.u) ...what do we aim through common sense? That is something that most of us should have, but what is a good faith common sense? (@o@) Returning to the blood transfusion example, a Jehovah's Witness physician could classify as common sense to not provide blood product to a patient. Conversely, a non-Jehovah's Witness physician could override a patient's blood transfusion refusal due to common sense. Not only does common sense provide an undisciplined approach, but it tells us nothing about the priority (i.e. whose common sense should prevail) □ (^ • _ • `) □.

I would like to say that the next classes were not headache-cringly (they weren't always that bad) (= _=). But there was no way in telling what would be taught on the Ethics class; regardless of the syllabus(>ლ). *The best analogy I can think of is that the syllabus is a broken compass, and you are thrown right in the middle of a deep, thick forest, pouring heavy rain and pounding thunder in your ears (↯↯↯). After enduring two hours, you were free to go to your habitat (study room, library, or anatomy lab).* This should not be a surprise (@_@), Lisa Lehman and colleagues recognized that “despite widespread

^k Bronner states that the “distinction between doing and allowing harm is often invoked in ethics [...] doing/allowing distinction should not be confused with the intention/foresight distinction” 10.

Bronner's two notion of causation¹⁰:

Causing as difference-making: X causes Y if and only if X makes the difference to whether Y occurs.

Causing as doing: X causes Y if and only if X's involvement in Y's occurrence falls on the 'doing' side of the doing/allowing distinction

agreement ethics should be taught there is little formal consensus concerning what, when and how medical ethic is best taught¹¹. Meanwhile, Carrese and Sugarman concluded that bioethics is a relevant component to the physician and that ethical education should be improved at all levels in the medical profession¹². Another issue would be time constraint, the medical curriculum is squashed in a 4-year time frame (._.). However, scientific medical advancement goes at a higher rate, we only need to glance at how many articles are uploaded in *PubMed* daily (._.). There are new fields such as genetics, and major contribution in biochemistry and pharmacology; all necessary information for best clinical practice (._.).

Unless the Accreditation body says otherwise, we only have four year in medical school to comply with LCME Standards: 7.7 Medical Ethics, 7.4 Critical Judgment/Problem-Solving Skills, 7.5 Societal Problems, and 7.6 Cultural Competence and Health Care Disparities¹³. This calls for a consensus (0) on time-effective curricular approach. Medical schools offer an advantage: they are controlled environment where educational strategies will impact millions of physicians through years (rather than trying to moderate the behavior of independent physicians scattered in their practice)¹⁴.

However, before jumping to teaching techniques (〰), there should be an agreement of what we want to teach physicians (〰). Singers offers the following components¹⁵:

1. *Address effectively the disclosure of bad news, informed consent, confidentiality, dishonesty, research ethics, end-of-life care, and resource allocation*
2. *Recognize ethical dilemma*
3. *Relevant knowledge and application of norms, laws, and policies*
4. *Communication and negotiation skills*

In other words, it would be effective to have medical students focus on specification and balancing of the biomedical principles (〰). Would a patient rather have a physician an expert of the moral theories, or shielded by common sense? (〰) Or a physician that knows how to recognize and perform correctly an informed consent? And trust me, the only thing achievable in a two-hour lesson of crumpled moral theories is a monumental headache (>0<). The questions should be revolving around the *ethical essence*:

- What do we want our physicians to be competent at?
- What are the current challenges that patients are facing (i.e. Opioid crisis)? How does Ethics play a role in mitigation?
- What are our take home messages? What are the tools we are going to teach physicians in training for them to become efficient?

Although, techniques should be addressed after the goals and objectives. I believe that there should be empirical exposure as early as possible. (〰) Sitting two hours

with heavy ethics information in an amphitheater for two years is not practical (>ლ).

Students need to be exposed to the wards as early as possible, under the ethical scope.

Ethics should also be taught at the bedside, where most of the ethical dilemma occurs.

One day something snapped. I was sitting in my usual spot (~^~), favorite black pajamas (AKA scrub), cheerful and vibrant socks (Mom's courtesy to cheer long days of missing sun) (←_←"), and hot chocolate in hand (^-^)_旦" ...oh and of course, the laptop with eye-eating bright light in front of me (¬_¬).

I don't remember, who was giving the lecture, but the take home message still resonates 4 years later: "Every decision is correct." (>ლ)

Really \(-.-)/? Really (O_o)!!! For the love of... \(#¬.¬)/ I have been wasting my time all these months. Couldn't they have told me this at the beginning? (>ლ) That whatever I do would be fine (unlimited immunity) \(-o-)/. Sometimes, other faculty sat with us to hear the lecture; and I think they picked up the dark atmosphere \(-^-)/. They started to question what their colleague meant, giving them a chance to "mend" what they said. We had 5 seconds of feeble hope (。●_●。), which was unmercifully crushed(;;-)... "You know the theories, it depends which one you choose, or what principle you think is more important, they give you different correct answers, so every decision is correct".

I heard shuffling sound in the background, and the loud snap of the amphitheater door.

“Before you go, it is time to talk about your final work six months from now.” – a few students walked out (•.•); the rest just stayed like wax statues (-.-;). “You have to assemble a group and discuss an ethical dilemma. I will give you a choice on how to choose your case though. You could talk to me, and we could arrange a hospital visit or you could watch *Fatmagül*¹. The power point requirements will be revealed later on the course. That would be all.”

Here was an opportunity window \(\text{OoO})!\) I needed to know what the attendings were talking about. They had experience in the field; whereas, I had not even stepped in the hospital’s cafeteria yet \(\text{(*_*)}/\).

Furthermore, if we had 2 years of clinical exposure (empirical practice of physiology, pharma and anatomy), why should we wait so long for ethical exposure? \(\text{OoO})/\). In the following week, I approached a few classmates that I knew had the same disturbance in the force as I did (\(\neg\).-\)). The team was assembled within weeks. In a matter of months, we had the date and time settled, and also roughly half of the class on board. Squeezing the time within our curriculum was a challenge \(\text{^XO^X})/\). I remember

¹ *Fatmagül ün Sucu Ne?*: Known in Puerto Rico as “Fatmagül” was the first Turkish TV novel aired at the island’s local channel. The hardships caused to the protagonist after her rape could be an option for an ethical discussion.

that we even bargained with school officials to allow us to go after hours, but medical students have curfew hours due to school policy. It helped protect study time, but we felt that it was worth to have 4 hours or so less for our own in exchange to have this unique ethical experience \(*o*)/.

Despite everything, the course faculty were willing to compromise and were flexible with our curricular need. The Class of 2019 was the first class to attend what we called Structured Ward Rounds (SWR), guided by Dr. Edmund Pellegrino's Ethical Case Work up^{16 m}. We received positive feedback (^o^), and the Institution granted us permission to implement the SWR for first- and second-year medical students as part of the ethics curriculum (^o-)/. Although we found SWR enjoyable and a great learning asset, the investigation team had not developed a tool to measure the SWR effectiveness. Nonetheless, if ward rounds were to be systematic, they would provide reliable teaching opportunities¹⁷.

Little did I know, that the SWR would be the catalyst for pursuing my MBE(^o^). On April 2018 (roughly 6 months after Hurricane María), we were giving an oral presentation in Baltimore. Previously, I had a nagging feeling that I was barely grazing the surface. I had the honor to meet Dr. Daniel Finkelstein (I was set up to present on the same block at the APHC Conference). After talking, he knew about my interest of

^m The SWR article is found on page 52 (Altiery De Jesús, et al., 2017). The article is written in Spanish.

formalizing my bioethics' education. "Why don't you formalize your ethical education at the best institution?" I still smile fondly at the memory, that was the first catalytic step for cherished time. I recall asking the innocent question "Where?" "Well at Johns Hopkins, of course."

I was euphoric ♪(¬_¬)♪. I had time (barely) for the application cycle...but being the overthinker I am, other aspects started to creep in. I was one year away of ending the MD, third year was not kind...I was exhausted (~_~). Furthermore, it would be my first time studying "abroad", and what about expenses? I remember the conversation after dinner.

"This is your shot. And the opportunity is now. By what you have told me after medical school there is less time." – pointed my mother. "Do you like the topic?" She has the ability of Rafikiⁿ, and I am not joking...since I can recall, the most hardcore conversations are just guiding questions.

"Yes."

"Of course, you do. You dragged us into the investigation!" – bounced my sister pointing at herself and our younger brother. "Without pay I may add." - The three of

ⁿ Rafiki is a *Lion King* character. There was one time (either at one of the movies or at the *Timon & Pumba* TV series) that someone goes and ask him for counsel...during the interaction Rafiki does not have a chance to intervene. However, he was thanked because he "helped" in providing the solution.

us chuckled, it was our inner joke, I recruited two high-quality undergrads for free (^o^).

“What did they counsel you?”

“Some people at school pointed that I should bet on an MPH rather than an MBE, if I wanted to do **this** anyway.”

“Are they going to sponsor you?” – I smiled; I knew where mother was going. “If ethics is a field that you like” – my sibling snickered, lately we were having more abstract-concept conversations ~(^▽^~). “Then you should go for it, don’t overthink this and start moving.” – *A rare event indeed, mother was rare to openly disclose her opinion.*

After thinking through the night, I made a crucial decision in my professional aspect. In a blink of an eye, I applied to the Berman Institute-Johns Hopkins School of Public Health, and started the epic quest (🔍) of documents and official permission in a post-María country, where we barely had internet service, buildings were massively destroyed and the postal office, was officially the snail office (🐌). My guide and stress-reliever for the admission application process was Senior Academic Program Coordinator Penny White, who was referred by my future MBE director.

I remember the email, it felt like high school and undergrad all over again(°.°). The phone made the inbox-email sound(>><<) . I went to look at it... It was from the MBE program, the preview said *Dear Vivian, I am pleased to inform...* I jumped from my

chair \(\^o\^o\)/ and got out of the small classroom. I called home, we promised to open the email together. I tried to be quiet on the hall (massive failure I believe). "I did not open it but, it said *I am pleased to inform you.*" - I squealed...I think that the end of the sentences I was shrieking (\^o-)/

I heard shouts on the other side of the line, we were in conference call (my siblings were at the university, my parents were back home).

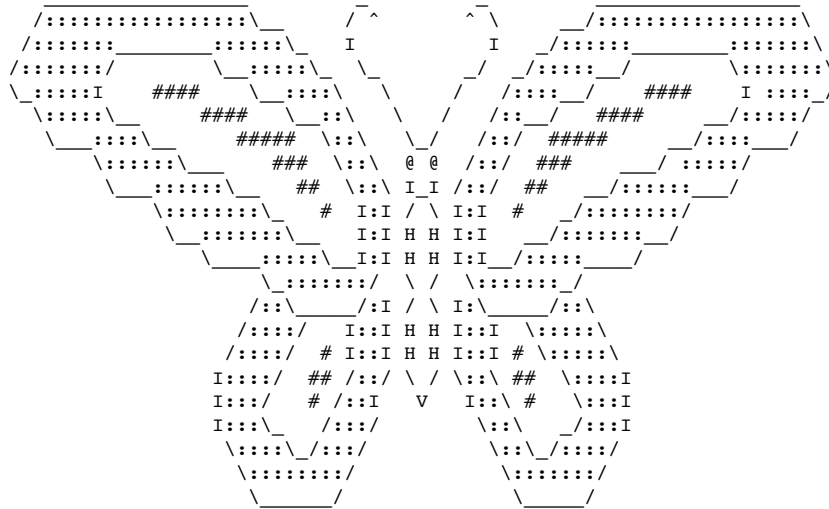
"Hey, hey, hey." - I heard my brother said. I knew that tone. _/_ "Are you sure you got accepted?" - "Well duh!" - retorted my sister. "Who in the world would put that they are 'pleased to inform', and then reject you!". "I would." - that little devil from the sky (_-_). Everyone burst out laughing.

I think we talked about a few minutes; a list was forming once again (Penny knows firsthand about my lists (\^o-)/). Seeking an apartment, post-admission documents, budget plan, snow clothes and the academic leave permission.

"Don't you guys have classes?" - said my mother from the other side of the line.

"Had?" - tried my brother. *Clever!* (_.-) "Don't make me go to your department. (\^.-)" - joked my sister. *Not so Clever, bro!* (XD) Both of my siblings were studying at the same institution, their departments were minutes apart. They were studying at the same institution I graduated from (._-_).\...

The Forgotten Text: The Practicum Component



Prologue

Chapter 5

Ethics Committees and Ethics Consults

\(^o^)/ I think that it is the closest keyboard-emoji that I can convey for the feelings during my first Committee sitting. My practicum mentor recommended to me a couple of books in order to understand clinical ethics in-depth and the committee dynamic (~^▽^~) . There has been a couple of times where I have reached eudaimonia throughout my lifetime, and this was one of them. Here I was, as a fourth-year medical and first-year MBE student, sitting as a guest...Definitely this was one of the best birthday gifts, yeah, I know, geeky but proud \(^o^)/.

As a side note, besides common sense, I am committed to my oath as a physician in training to keep patient information confidential. Furthermore, I also accepted the confidentiality agreement of each Committee and IRB. In other words, the detailed experiences of the cases that I had the opportunity to learn, will remain in my mind alone. The same with my ward's cases, I owe patients respect and gratitude by allowing me to learn from them during my professional formation. Therefore, I will focus on the essence of the moral dilemma, as well as inflicting changes in the cases' facts, erasing

any trace of identification. Moreover, the text will be revised by my mentors and faculty members.

I had the opportunity to observe Ethics Committee at two Johns Hopkins hospitals. Both committees had similar features, diverse composition of experts ranging from physicians, lawyers, social worker, nurses, chaplains and patient representatives (◉◉◉). The expertise to distinguish between a legal and ethical case, the synchronization for the next step in action, the insights of opposing opinions in the course of action...an astonishing experience for an MS4 an MBE student (◉◉◉) (I think for everyone) \((◉◉◉)\) / .

Although both committees had different cases and different patient populations, there were topics that were addressed: decision making capacity, end-of-life issues, refusal of golden treatment by patient, resource allocation, spirituality, and religious approach. Something interesting is that Ethics consults are requested by healthcare professionals, but also by the patient or patient's family. Another aspect is that "ethics" doesn't have a negative connotation. Before the MBE, I thought that "ethics" was something invoked when the physician was being dishonest (◉_◉) ; they were the police force of the medical license. Well yes and no, ethics actually goes beyond just policing professional behavior. Ethics serves as a prevention for errors or escalating

issues. It is a tool that can provide benefits for the physician and the patient's health outcome. Ethics is more than judging healthcare professional behavior\(^{oo}\)/.

Although different, I remember that our team had an ear-pulling situation (*and with reason*) (>>.<<) from an Administrative Committee, who was the gate keeper of the hospital beds under the distressful and disastrous situation of Hurricane María(′_′). Long story short, there was a point where we had hospital-admission-seeking behavior...as said by one of our patients "Here [at the hospital] I have food, air conditioner, water and electricity...I got nothing at home. My home was destroyed". This was a heartbreaking situation, especially in the pediatric population, where some patients suffered malingering by proxy^o. We understood the situation of our patient, but at the same time, we needed the resources (admission bed, power supply, water supply) for those that were in dire need of healthcare. It would be unjust to not provide the same opportunity of healthcare to the rest of the population.

Ethics for Lunch and BI Seminars

I remember orientation day at JHSPH. "We know that you guys can't properly function with an empty stomach..." (*_*) An ingenious idea, a cool way of maximizing our time \^(\ ^ \nabla ^). It caused massive laughter at Feinstone Hall, a majestic

^o Malingering by proxy is when parents or caretaker make their offspring sick for profit¹⁸. Do not confuse with Munchausen syndrome by proxy where parents or caretaker makes their offspring sick in order to seek attention¹⁸.

amphitheater. JHSPH had plenty of guest speakers and seminars running year long, most of them occurring during lunch or early in the morning. Hence maximizing the possibility of student participation. In exchange, they would feed us with either breakfast or lunch. Everyone cheered at the bargain \(*O*)/. It felt like a Black Friday Deal (I must confess, I have never participated in a Black Friday, though (•ω•)/). An astonishing idea, you had a lunch break, did not need to worry about cooking or fetching food, had a whole hour of innovating information, and your energy was renewed to continue with the rest of your classes (┐─┐_─┐).

The Berman Institute (BI) offered seminars, the topics ranged from clinical, food engineering and current hot ethical topics, such as CRISPR. Meanwhile, Ethics for Lunch was offered by each Hopkins Hospital, they had a clinical ethics focus. The modalities ranged from presentation to panel discussion, with ample opportunity to interact with the audience. These experiences also became part of my Practicum, they allowed me to gain more insight to the theory learned during course work.

Ethics Teaching

Ethics teaching ranged from medical students to residents from different specialties(◦●◡◦). The topics were focused on ethical issues that may be encountered throughout the profession and tools on how to mitigate, avoid or solve them. Most of these sessions were done in small groups. Chapter 2: Professionalism was

a glimpse of Ethics Teaching. In later chapters, more experience will be narrated along with the ethical analysis taught during my MBE. The sessions were highly focused and intense\(^o^o\); sheer concentration from the audience. Most of the time (if not always) I had questions to ask afterward the lessons. Topics that were discussed included informed consent, delivering bad news, VIP patients, professionalism, healthcare team conflicts, medicolegal among other high yield topics.

Participating in these sections was blissful, it is the equivalent of standing in two places in the same time \(*o*\)/. And the last time I felt like that was when I was around 8 years old and my mother pulled over at the boundary between Carolina and Canóvanas, two counties at Puerto Rico. “There you go, if you stretch yourself you will be simultaneously at two places”- I don’t know how much time I stood there splitting as much as I could, but I do remember the joy of the great achievement (^o^). It wasn’t until years later that I stood simultaneously at three places. There is an exact location in the attraction “*Parque Nacional de la Cavernas del Río Camuy*” (*Camuy River Cave Park in Spanish*), where it has the boundary between three different counties. I am seeking to break the record soon (.o.).

Clinical Shadowing Experience

During my MBE, I also had the opportunity to shadow ethical cases in outpatient clinics and during Ethics consultations. This experience is compared to what I could

imagine to be an archeological field trip. Literally, you are between two worlds: Ethics and Medicine. The dynamic is very different from a hypothetical case....I do not have enough words to describe this (n_n) nor emoji faces.

Composite Experiences

The following statement may seem like a paradox, the BI-MBE is highly structured but at the same time, highly flexible. There are core unbending requirements, which allows a solid foundation for their students. Yet, the curriculum is flexible enough to draw on each student a set of skills, interests, and background. Throughout the year, the BI and JHSPH promoted a variety of activities that do not fall in the above classifications; hence, the “composite experience” section. My second interest is Research Ethics (👁_👁🌸).

I had a fair amount of banging my head (to the point of creating a unicorn horn) during my first IRB experience during the first summer at medical school *“How could offering one MISERABLE bonus point for Ethics class be undue influence? How was I going to increase participation from my classmates for the post-SWR survey?”* [Add the cricket sound] (=.=) Yeah, I know, I was almost too far gone (i^i). Of course, it was undue influence! (ノ_□_ノ) Even my justification spurts undue influence (o_o). This *is* research, not a marketplace -sheeeesh-... I banged my head a little bit more (>_<) when I made the retrospective research and also involved the Hospital Board + my school IRBs.

Nonetheless, all of them were good empirical experiences that helped me enjoyed when I sat at different IRBs as a guest (u _ u). The IRB's goal is not to make the investigator's life miserable nor comfortable, the IRB's purpose is to ensure the safety and ethics of the investigation. We only need to glimpse back in time to see little bits of what lead to historical research atrocities, under what I want to believe were good intentions of investigators.

Another opportunity was to participate during Clinical Ethics Research in Progress (CERIP) sessions. The BI faculty takes turns to present to other faculty members their research. This session serves as a consult for advice and opinions regarding methodology, protocol development, data analysis, among others. It is interesting to listen how different minds converge and instantly create a product. The analogy that I can come with is a cake \ (•◡•) /. I know that there are people out there that find cake confection fascinating. Water or milk, flour, egg, butter and desired flavor. Radically different ingredients to which their "uniqueness" is lost in the final product. Even depending on the ingredient ratio or the method used, different products could be made (e.g. pancakes). This is a trait I have stumbled upon throughout JHSPH, even at the Happy Hour Fraction (a school traditional Friday get-together) where different mind-entities join and have a good time (we tend to slip back into our lovely "geeky" talks) (~◡~)~...It is a nice and unique group, we even auto-denominated that

“Awkward Dancing” would prevail at the Spring Gala, and it did (XD) (another lovely school tradition).

Lastly, activities such as the Henrietta Lacks Memorial Lecture, End of Life Project-Theater of War Production, and Conferences (e.g. APPE Conference) nourishes the ethical and personal experiences. These two activities in particular allowed me to appeal to suppressed material, concealed treasures for me. My major was in Cellular Molecular Biology, consequently this means lots of genetics exposure. I had the chance to meet one of the great icons in genetics, he was mentioned in almost every Cellular Biology course: Dr. Francis Collins, director of the NIH. It has been a long time since I had a *Drosophila* phenotype prediction using X^2 , genetics (as in my bachelor’s degree) is not used during medical school or clinics. Nonetheless, it is still a part of me, well five years of my life in the topic (^o^).

Meanwhile, the End of Life project used dramatic readings from Sophocles’ *Philoctetes* and *Women of Trachis*. Definitely this is practically the equivalent of watching a *Disney* movie and going to *Disney on Ice* (❤️🍷❤️)... My high school had a very similar paradoxical structure to my MBE; structured but flexible^P. We were required one literature reading per semester, the choice was ours (๖° ๖° ๖°). This allowed me to explore my fascination with mythology, so I filled my quota for 9th-Grade with the *Iliad*

^P Among the three [siblings] I have the most hybrid education. I was enrolled in the traditional system until the first trimester of 8th grade. The rest was under the Homeschool system.

and *Odyssey* (❤️😊❤️). Subsequent years I read the *Greek tragedies*, and they were re-read during the Humanities Introductory course at college. The play allowed me to see another perspective for my thesis (which involved the ethics of assisting death).

Another powerful source are the national conferences. I had the opportunity to assist to a Teaching Workshop and a full day at the Association for Practical and Professional Ethics (APPE) annual conference. The only challenge that I found was that I couldn't not be at two places at the same time. (I truly wished I was 8 years old and that it could be solved by stretching between the boundaries) \ (•😊•) /. Each session had 3-4 concurrent presentations with a wide range of topics from clinical to military, to business, to technological; a true ethical buffet.

All these activities constitute my Bioethics Practicum Experience (¬■_■). Along with my core requisites, the Practicum has been an essential experience for my educational formation. The time dedication goes beyond the required 48 hours for graduation. Nonetheless, every single second is irreplaceable and invaluable. Without further ado, I will proceed to the in-depth ethical analysis of selected experiences gathered throughout my Bioethics Practicum (~_^).

The Differential Diagnosis (DDx) of Refusal of Care

Dr. Mark Hughes & Dr. Joseph Carrese

Teaching Ethics

Chapter 6

Early in the morning a group of surgery residents gathered to take a lecture regarding the Difficult Patient and Challenges faced with Colleagues. Throughout the discussion, a probe-question was placed in the table "*What is the differential diagnosis of Refusal of Care?*". Basically, that is one of the main problems, seldom we see a situation where a patient is labeled "difficult" because they don't agree with their physician (7.7).

After the resident chatted back and forth with both lecturers, differential diagnosis (DDx) were produced.

1. Misunderstanding/Misinformation
2. Ignorance/Poor health literacy
3. Discomfort/Pain
4. Fear
5. Bad outcome of family/friend/Self in the past
6. Adverse risk
7. Lack of Capacity

Yeap! All of them alone and combined, practically you have from 7 to 5,040 combinations of why a patient may be refusing treatment (considering only this seven categories) (@.@) The good news is that healthcare workers only need to master a single technique...*effective communication* (^). Easier said than done. Ironically, by the time I was on my third year I had 26 years of communication experience (take away a few months, although high-pitched crying was highly effective in my early days).

Regardless of my communication experience on a daily basis (.'_.), I encountered many combinations of the differential diagnosis. The *Google*-Symptom (sorry for the rest of Internet Browsers), which could fall on the poor health literacy category, provoked an inner face palm (-^). I recall one patient that challenged every recommendation based on Internet findings (-_-)...I think that I did not encounter many *Google* Diagnoses due to the poor signal on the Island after the Hurricane. I remember the slight frustration at having a constant resistance (ಫ_ಫ)....How many times either my family or I had to turn on the generator and study at the weirdest hours (¯_¯), or just go to the yard or roof and study \ (o_O) /, maximizing the sunlight....(Those were deep connection with nature ...(-.)). Plus, it was not my humble roof-yard opinion \ (¯_¯;) / and two years of lecture training, I had a few residents and one attending pulling the strings too. Nonetheless (ಠ_ಠ), it seemed that no matter what explanation or how much time is spent, *Google* seemed to always be on

the lead $\backslash(^{\circ}_o)/$. *Just a deep breath, recall your "difficult patient lecture" ($\smile_{-}\smile_{-}$) and move on ($-^{\wedge}-$) ... acknowledge the patient's knowledge and you know the rest.*

Eventually, the patient followed the recommendations, but I think the team labelled him difficult due to the extra-time we had to pour against his *Google* bullet list every single day. Fear, discomfort, and any previous bad outcome experiences are challenging and delicate $\backslash(^{\circ}o^{\circ})/$. Most people had experience at least one fearful experience, especially in childhood. Most of the time is the caregiver that provides reassurance and helps the person overcome their fear ($^{\wedge}o^{\wedge}$). In the clinical setting, it is very difficult to persuade because the healthcare worker cannot say "Don't worry I swear that everything will be ok" ($\smile_{-}\smile_{-}$). Because in reality, I don't know if everything is going to be 'ok' ($\cdot_{-}\cdot$). To start with, is the "ok status" the same for the patient and me? ($\times_{-}\times$) Furthermore, fear creates misunderstanding, and mitigating them takes time. The relation deeply depends in the communication and ability to build trust in the relationship.

There is one diagnosis that we did not discuss, but it has followed me since the second half of my third-year clerkship. It was my Internal Medicine-Floor Rotation.

"Fifty-three-year-old female otherwise healthy prior admission she came due to a Hemoglobin around 4-5. Differential Diagnosis?"

"Cancer ($\blacksquare_{\wedge}\blacksquare_{\wedge}$)" – I said.

"Where are we in first year?" - I still don't get why an MS1 is so unworthy (. ' _ ' .) .

Someone was in a foul mood today (¬.¬). Later, I learned that for this particular attending when asked DDx you had to pistol like the Wild West all differential diagnosis " _ 3 = (■ 5 ■) = ε H " the usual *Family Feud* approach was unacceptable (¬_¬).

"Anemia?" – offered my fellow combatant.

"Are you asking Me?! Which one and why?" – This was going to be interesting and challenging (¬_¬). Well welcome to bootcamp (u.u). Not my favorite learning approach but adaptable ¬_ (ヾ) _ / , practically my high school was a tailored military driven curriculum, which allowed me to learn discipline and structure beyond academics.

"Who will take this case?" – I was snapped out of my thoughts, practically everyone had poured DDx " _ 3 = (∘ 5 ∘) = ε H " , but apparently there were more (⊙ _ ⊙), and my two hamsters were running at full capacity ☞ (→_←) ☞ .

"I will."

The medical history shouted GI cancer: weight loss, stool shape change, rectal bleeding, the anemia, her age, her family history...deep down she suspected it too.

"What is the plan?" - the patient asked me.

"I would have to speak with my superiors, but the next step will be to have a few tests."

"Tests searching for what." - The question was more of a statement than a question.

Her eyes said it all, she knew what we were suspecting. I felt time slow down... *Test*

searching for cancer? Test searching for cancer (do it more secure, woman ^(>_<^)). We suspect you may have cancer, CANCER CANCER CANCER CANCER. You cannot blurt out that she has cancer, what if she doesn't (ಠ_ಠ)ノ. The attending didn't look convinced about Cancer. Well, our attending didn't look convinced of anything ^_ಠ_ಠ_/.... Hurry up! Remaining two more seconds quiet would be worse than blurting cancer (>>.<<).

“One of the possibilities is that you may have cancer. We need test to make sure you don't have it.” – looking back the wording I choose, were bias(~~~). Later during my MBE seminar, Practicum, and Pediatric Oncology Rotation at Bloomberg Children Hospital, I learned to adapt a more neutral language. Instead of “make sure you don't have it” a more neutral approach would be “We need to test to know whether or not you may have cancer”.

She nodded. “If that is what you are thinking I would like to leave the hospital.” – she said calmly. I did not expect any of this, her calm reaction nor her desire to leave the hospital without ruling out cancer (•_•;). *Perhaps it was the way I frame my answer?*

“Why?” – I asked her.

“My father died of cancer.” – she responded. “And it was awful.”

“I am sorry for your loss. However, knowing at an early stage could help in the management”.

She shook her head. “I know but then after the test what would happen?”

“We are searching for other causes too. But in the case that the test is positive for cancer, we would discuss possible therapeutic treatment”.

“Exactly. Test will lead to more test, and treatment.” – There was something going on, but she was calm and secure about her decision.

“Are you worried about the procedure, about the experience?”

“No, I know that it would be hard but better than my father, due to technological advancement.” – Now I was lost^(°.°), this refusal was not due to *Google*, and apparently neither by previous bad experience (with staff). She did not seem fearful either.

“Why would you prefer to leave the hospital?”

“Actually, I would like to be healthy, I do exercise, try to eat healthy, I don’t smoke nor excessively drink. I have never done drugs. But I don’t have health insurance.

Regardless if I know today or tomorrow if I have cancer, it would not change a thing because I cannot afford it”.

I was not prepared for this (+_+). However, everything moved like a reflex muscle, from the standardized practice with the “and if” situations. “If you would like, we could connect you with a social worker. But right now, we are worried about your health”. It was not the same, it did not feel the same (•_•). Perhaps because I realized that this was a real case, maybe because in the middle of the natural disaster, things wouldn’t work as efficiently (~_~). *Do not give false hope, but do not kill hope either.* Easier said than done. What would I gain in spelling the detrimental side of the story, I knew, she knew

it, everyone in Puerto Rico knew it...things were not like before? \((-^{\wedge}-)/ We had two options, sit down and wait or start walking forward. I remind myself to keep the most neutral face possible.

She gave a deep sigh. "Alright, I will try."

Here is another DDx for the "difficult patient": sometimes, there are things that are beyond the physician's and patient's control. There are other socio-economic factors that are playing in the background and strongly stir the decisions and perceptions. The physicians' responsibility is trying to mitigate and aid (either by direct action or by referring to the correct resources) the obstacle that may label a patient "difficult". It is our responsibility, as physicians, to practice the Principle of Justice...excusing oneself behind the "difficulty" label cannot be a waiver to our duties $(-^{\wedge}-)$.

In the Patient's Shoes

Chapter 7

An interesting assignment for my Practicum was to place myself in the patient's shoes. A difficult task, indeed ☹️. The difficulty, at least in my case, is not the lack of imagination or empathy. In fact, the difficulty came after my first MBE year. It has not been uncommon for me to do this type of exercise, partially (actually ☹️), completely my mother's fault (^^). How to live a "correct" life? A very hard question which I don't pretend to answer in the near future, but a question that everyone should be asking themselves on daily basis (^^). Nonetheless, during my human development, my mother taught us a simple rule to cope with the previous question, a dogma which has worked so far for me and I plan to continue "Don't do what you would not like done to yourself". There are similar phrases out there, but the tone and chime that my mother used are embedded like a hardwire. However, for that dogma to work requires another component: cultural competence (>_>). This was embedded in my early years as respect for others and in simple words "We are not all the same, every single one of us is unique...you have to respect that". Looking back, I think that my upbringing was very philosophically based (^^).

Returning to the assignment, if I have done this roughly for 27 years, why do I find this phenomenon fascinating now? Easy, blame the MBE (^.^). I don't consider that I have lost my empathic touch; however, I have re-lit the torch of curiosity and insight. I wonder, can I really be in anyone's shoes? There are two types of empathy. Affective empathy triggers the sensation and feelings towards another person's emotion¹⁹. Meanwhile, cognitive empathy is the ability to comprehend the emotions of others¹⁹.

Affective empathy seems the easier from the two, at least for me ٩(๑)๑٩. If I see suffering, I feel sad, sometimes even helpless when there is not much to do. Now, comprehending another person's emotion, I think that the highest achievement we can reach, is an estimate. In order to really comprehend a parent's suffering when they see their child enduring the adverse effects of chemotherapy, I would need to have the experience of being a parent. Not only that, I would need the memories, the experience of that particular parent-child relationship. Furthermore, I would need to experience the parent's cultural and belief system values.

I found myself that I could *understand* that parents were afraid for their child. They were overwhelmed with their child's condition and the nefarious therapeutics' adverse effects. Yet, could I really understand what they were *actually* passing through? (~_~;) I don't think so...empathy is a close estimation, just like biostatistics can predict the population tendency value through the estimation of a sample. By no means, I conclude that empathy is useless, in fact it is necessary (-(~)~)\(^(~)). Empathy helps in

patient centered healthcare, as well as intra- and interprofessional communication¹⁹.

Nevertheless, I wanted to glaze the surface of a more in-depth reflection...consider the limitations of oneself. Especially when we assume that we are already empathic and pretend that we can understand 100% how patients feel. Without further ado, I will start analyzing, in the patient's shoes, a few selected cases.

Case of a 75 years old female s/p distal pancreatectomy and splenectomy. Presents for a routine checkup. Her main concern is high blood level pressure, her systolic has remained in 140-150s. She is a current smoker and has a history pulmonary emphysema and arthritis. She is not depressed and knows that smoking is adverse for her health, but it is "hardwired on her brain".

My pre-MBE analysis would be something like: She is alone and is concerned for her health. There must be other factors worrying her. Is she anxious about her family? ...and something along those lines.

Post-MBE analysis...buckle up for the journey (@.@). First, I need to concentrate again(☺^☺). I have to forget that I am 27 years old female, I have not studied medicine nor bioethics. I am not the eldest of three, nor are my origins from the Caribbean. I have to erase that I am a never smoker and oddly (for the "2 standard deviation in the population"- poorly attempted a lawyer joke) (>☺) ... forget the ATV's muddy adventure with my siblings (☹_←), or the asthmatic seal sounds karaoke

seasons ♪(¬_¬)♪. Difficult...but what I am trying to convey is something similar to the veil of ignorance state by John Rawls.

Now, I need to pick up the pieces off the puzzle, I am 75 years old female. I have kids and grandchildren(☺ _ ☺). The relationship with them is unknown to me. I don't have that type of insight. I am currently retired and find walking with my friends meaningful in life. I am also a cancer survivor, and smoking is hardwired in my brain. I have attempted to stop before, but to no success. *Am I worried of cancer relapse? I know that smoking is bad for my health, it is linked to pancreatic cancer....* Are those though accurate for *me*, or is it Vivian's medical knowledge slipping into this process? (☹_☹) Nevermind, let's continue with the exercise: *I feel anxious, my knees are moving up and down while I sit here. I am almost hugging myself, trying to shield myself from the world. I am really anxious... but about what exactly?* And that is when I find my limitation and getting exactly on the patient's shoes. Could it be due to a family member, could it be economical? (•.•) And if so, what aspect of family? Is someone dying? Do I have a misunderstanding, or do I feel that I am not valued by my family? And so on with the other situations and choices (@_@). What are my priorities? ... My real priorities? Is health one of them?

The same happens when we deliver bad news, and it happened to me. I was on my third-year clerkship, the biopsy returned positive for cancer. I did my SPIKE (as

good as third year medical student can do), and I received a blank stare, a poker face...absolutely no emotion at all. Of course, I read (always the blasted books (¬_¬)) that patient's reaction could range from outburst of sadness or anger, to laughing madly to uttering no emotions at all...but seeing it firsthand ...it was unsettling. I found myself in silence, prompting my patient to talk, but we just kept staring at each other. His wife was quietly crying...I wanted so badly to say: *"Everything is going to be okay"*. And I had to bite my tongue, *remember the coat, remember the coat, remember the coat* (ø_ø). I couldn't say that, I didn't know if "everything was going to be okay" and again *Is my "okay", our okay, your okay?* (._.)(. _.) Furthermore, the responsibility to convey truthful information, to not give false hope.

"You are not alone in this; I know it is a lot of information. Do you want to talk about this later?" - He just nodded, and I returned the nod. I gave two steps toward the door. "Let us know if you have any question or need anything" - I said addressing his wife.

Looking back, I should have pushed a little bit more (~_~). I don't think that I behaved unprofessional or unethically. It could be argued that I respected my patient's autonomy...he was hospitalized, so there would be more contact. However, I would not be comfortable with my previous approach in an outpatient setting (•_•). I was empathic, I reacted to my patient's suffering, and I *understood* that the information was too overwhelming and that perhaps he needed time to process the information...

I would classify myself as empathic (at least a close estimation). But I think that I overstepped in the understanding-part(=_=). Was it I, that wanted more time for the information to sink in? I didn't actually inquiry what he was thinking.... I just assumed that he wanted the information later. Therefore, I unconsciously guided the conversation under my presumption of understanding, under the pretense of being empathic.

A more estimated empathic approach, would have gathered more information "What are you thinking now?" or "Tell me your thoughts" ...perhaps included his wife in the conversation? Then, empower him to decide when would he like to have the conversation. In the hallway, I realized that I forgot to offer tissues, as per protocol of SPIKES...I practice it, I perfected it with the standardized patient...and yet in the moment of truth I forgot about offering the wife's patient some tissues. That was my cold bucket regarding bad news.

Few days later, I was exiting another patient's room in the floor crossing my fingers that I was successful in the explanation (ಥ_ಥ). My task was to emphasize gently but firmly, that he needed to **STOP EATING AFTER 12:00AM!!!!** ಲ(ಠ_ಠ) This was like the third time that the 9:30am MRI or CT (or whatever study it was) had to be reschedule due to his non-compliance ಲ(ಠ_ಠ)...*"I just get too hungry"* - he would say to the team, *"Can you schedule it earlier on the day?"* Finally, my day was coming to an end \(\^O^\)/ . And I had an upcoming marathonic killer test early next week ಿ(ಠ_ಠ)┐ .

My feet were dragging me to the resident room, when I saw my patient's wife sitting in an abandoned bed at the hallway, her face shielded from the world, but obviously on distress. I went to my haven ☹(ò.ó)✂...

"I need tissues and a few alcohol pads." - I said to the nurse in charge.

"For what room? Patients last name and procedure?"

There was a new movement in the hospital, practically for some odd reason MS3 were banned from supply. The nurses were the gatekeepers on each floor(._.). Highly understandable considering that Hurricane María barred us from supplies (´_´).

"Her husband had been recently diagnosed with cancer; she is crying alone in the hallway." - The nurse looked at me, weighing if what I was saying was reasonable.

"I don't want to go to her with toilet paper..." - Really, I couldn't imagine myself going to her with toilet paper(>☹), because at that specific time there was no paper on the floor; and I could not wait until they restock them. She was in distress now, not later (ಥ_ಥ). Looking back, I could have gone maybe to another floor (•_•;). Maybe I was too tired, or maybe my brain was on automatic (´_´)\(´_´).

"Okay, give me a moment." - in less than two minutes she returned with a few gauzes and three alcohol pads.

I took a deep breath and found myself reciting the SPIKES...I stopped . *Just stop!* \(\^O^\)/

The SPIKES is a guide, but I would not base a delicate conversation in a robotic step by step.

“Hey.” - I said softly, bloodshot eyes greeted me. I offered the opened gauze for her to dry her eyes.

“Is everything okay?” - I made a mental slap(>ლ),. I still struggle to find a more neutral form of asking. Conversations are an interesting phenomenon. Despite her distress she nodded her head and said “Yes”. It had happened to me too. I go to the physician’s office because I am not feeling well, and most likely the response I gave when asked how am I feeling, is “Good” (☹ _ ☹). It could be cultural; it could be a defense mechanism...

“Is there something that worries you in particular?” – I asked, extending my hand offering 1 opened alcohol pad. Now this is interesting, I don’t know if there is scientific evidence behind smelling alcohol and aiding with stressful situation, but it is something that I have grown into ၇ (‘••’) ၇. You have nausea, here is your alcohol pad? (☹.☹) Did you passed out, just sniff an alcohol pad? (ò.ó) Are you in a distressful situation (not the kind of “I am going to take a test soon” situation), enter the alcohol pad(☹.☹) ၇.

She explained that she had a close encounter with cancer during the past years, and it was overwhelming to know that she would need to be in that pathway once again. She was also worried for her husband; he was too quiet for her liking and couldn’t decipher what he was actually thinking. “You know, he is the stronger out of

^၇ A weird type of cultural-informal “aromatherapy”. See Sniffing alcohol is thought to be a good cure for nausea by Bakalar²⁰. However, regardless of the intervention success (whether sniff calms anxiety or not), the essence is the cultural competence and let the patient know (in this case the patient’s family) that they are more than just a disease, that the team cares for the person suffering from the disease.

the two for this type of situation. He is the one always reassuring, giving me strength. But now seeing him like this..." – her voice broke and she started crying.

I placed my hand over her shoulder, I just wanted to let her know I was there, that somehow, I understood her pain, her suffering. I noticed that she had a crucifix. "Do you participate in a religious group?" She nodded. "I know that this is a hard situation and from what you are telling me, you and your husband could benefit from having external supports that goes accordingly with your belief of system". I remembered that she had a blank stare. "Yeah, we are Catholics."

It would have been easier for me, to just say what I would say to a close one (••). Because I would not need to consider the boundaries of professionalism, I would simply say "God will not abandon us..." or "You are in our prayers". However, I believe that would be incorrect, my function as a physician-in-training is to deliver and apply the medical information with care (which means that I am not treating only the disease but a whole person) (•_•). Nonetheless, due to the nature of the relationship: the patient is vulnerable, the physician has a greater knowledge regarding the conditions and treatment, etc., I have to be careful of what information I provide and how I deliver that information as well (~_~). If I were in my patients' shoes, personally I would not like that a religious topic nor belief would be imposed(._.)(._.); that is something that I would rather find in my privacy. I would not mind that chaplain

services may be offered, but I am conscious that I am not exactly seeking spiritual counseling from my physician (ಠ_ಠ).

I remember one time, with a close one where the physician said, “Well” – he said, trying to put the *puppy eye-I-am-so-so-sorry-face* “the only thing left is pray.” I don’t know if he was serious “\(^_o)/”, a failed attempt to empathy “ಠ_ಠ” or a mix altogether (>℥). What I do know is that I was barely in my teens and I frowned (and still do) at his “medical conclusion” (; _ _). Half of the family believed he was mocking the religious belief (ಠ_ಠ), the other one gave them benefit of the doubts (ಁ_ಁ). I was on the “mocking-team”, years later and seeing myself struggle, I am inclining myself to give the benefit of a serious, well-intentioned attempt to be empathic (ಠ_ಠ). “Would you like that the hospital’s Father came and talked to you?” She nodded. I could not imagine what the couple was passing through. These types of news are a struggle during the time we had “normal” communications, but now with the after-effects of the Hurricane, patients tended to be lonelier at the Hospital, most of the time severed from their support system. “If there are other questions or concerns, ask us. If we don’t know the answer at the moment, we will search for it. The important thing is that you are not alone in this”.

^r The Berman Institute’s lower level (physically-the basement) hosted most of my bioethical courses, but it also held many seminars and activities (like the white elephant). On November 8, 2018 Dr. Dariusz Galasinski gave a presentation in the *Share Decision Making Symposium*, hosted by Dr. Zack Berger. He critiques the physician’s attempt to empathy, which involved something along those lines....

A few tears spilled from her eyes, she nodded and muttered a “Thank you”. I gave her the remaining gauze and alcohol pads and squeezed her shoulder.

I returned to the resident’s room, I was definitely going to take a nap, before even trying to read another chapter of who knows what part of the body (✕ ∩ ✕). “How do you call the catholic chaplain?” They looked at me like I had grown another head (◎_◎). “Is someone dying?”

“No.” - I blurted out.

“Ah, okay.” – said my resident relieved, letting go the breath he was holding. “I don’t know, but I don’t think he is around at this hour. We need to talk to the nurses tomorrow and see how the process is. I have never called a chaplain before”.

So yeah, for some odd reason chaplaincy (at least from my rotation experience) was seen as something foreign to medicine (@_@). It was quickly associated with a dying patient, and sometimes even looked upon “as a waste of time” (>🍷). This is highly contrasted during my MBE practicum(☹_☹✕); chaplaincy is regarded as an official consult team. Consults are placed just like you would place a consult to any other service. This was crucial for the health care of our patient. Physicians are known for their curing role, sometimes we forget that we also have a responsibility to heal²¹ And as my thesis also suggests, physicians have other roles. I believe that in order to heal it is essential to take care of the whole person, including their spirituality. However, since the spirituality domain is out of the scope of the medical training; the

chaplaincy service is necessary (just like Social Work consult when physicians mitigate the determinants of health).

I don't know what is happening in the rest of the world $\neg_(\neg)_/\neg$, but at least during my professional rising (specifically hardcore biology courses), there has always been this invisible vehement battle trying to prove that God does not exist (and some proof that physicians are godly incarnations) $(\neg.\neg)$, instead of focusing on making new discovery $(>\infty)$. I remember one time when a lecturer (who was not an MD) bitterly declared, "Oh now I am in the presence of the "**Medios Dioses**" (which literally translate to English as *half-gods* (*demigods*), well I am a doctor too". $(\odot_ \odot')$

"Yeaay! Wooo! Welcome to the Olympian team $(\neg \circ \neg)$ " I didn't see the logic then, I was too tired and my mind was already thinking about "Match Gabapentin-Diagnosis Quest" $(\odot_ \odot)$ and the difficult decision between pork ramen or chicken ramen for the evening $(\neg.\neg)$. After having two philosopher mentors shaping the way arguments work in the MBE $(\odot'\bullet_ \bullet'\odot)$, I fail to see the relations between the claims $\neg_(\circ_o)_/\neg$, and I highly question the contents of the premise (o_O)and no I am not going to bother to search the hidden premises either $(\smile\wedge\smile)$. Some arguments are better left in the dark $\neg_ \odot_ \odot_/\neg$. I think, however, this is another manifestation of the *transformation hysteria thingy* that was discussed in Part I. It was seen in the people that I encountered that pleaded for my Neverland visa retention $(\odot_ \odot)$; it was also seen in the third year "gloriousness" referral $(\odot_ \odot)$ and also throughout some personal experience where the

physician's recommendation sometimes felt like the final saying in the conversation

(☹☹). I wonder, how much this language and/or attitudes embedded during the transformation process towards a full professional (⁠☹☹⁠).

The last case was a pediatric case. During the MBE there was a Fall submission in 2019 that called for a short piece in *Reflections on Trauma*. The title is [One Hug Away from Home](#). [Side note: It was accepted for publication on 2020 by Tendon Magazine!

⁠(^o^)/] Unlike the previous two examples, this piece was actually a wake-up call from my patient.

Futility a Fancy Trigger

Chapter 8

It should be no surprise that I encountered many situations beyond the healthcare team's control during my wards₁(('•_•`))_r. However, even if I *knew* that it was virtually impossible to save, cure, heal everyone...the frustration still seeped in (╯_╯). Come forth *futility*, a term I heard often. A term that seemed to bring some sort of comfort to all the members of the team when reaching a dead end (╯_╯)\(╯_╯). But was "*futility*" really "futility"? (~_~)

An elderly woman (around her 80s) with history of advanced Alzheimer and cardiopulmonary complications, was admitted due to a painful acute skin detachment. It simulated Toxic Epidermal Necrolysis (TEN), but there was no clinical indication for Steven Johnson Syndrome (SJS) nor TEN. During her stay, she could not move or eat. She could not open her eyes. Her only interaction with the team was mumbling and heart wrecking screams every time we needed to move her...even placing the stethoscope caused her great amount of pain.

As a third medical student, my responsibilities were to "pre-round" with my residents and then "round" with my residents + attending. During pre-rounds, we

asked the patients how their night was, how did they feel at the moment, and then proceeded to make a focus exam. The Heart-Lung exam was a must for every patient(^o-). Later, during rounds, patients were re-asked again the same questions and the exam was re-done either by residents, fellows or the attending. The term futility started to slip into my thoughts. Was it really necessary that we kept doing the physicals exams? I caught myself (•_•). Of course, it was necessary! \(>_<)/ Just because someone is old, has Alzheimer, and a very painful skin condition does not mean that the benefits of a physical exam should be waived(>ლ). Yes, it was awful seeing our patient cry, but it would be worse to have our patient with a developing pneumonia, or any other condition that would drown her slowly during her stay at the hospital... *Exactly, Bingo!* (•.◎) I could waive my pre-round insight.

Let's pause for a second, even if the following will hit my 3rd-year student self-ego very hard (ಠ_ಠ) (and the rest 3rd-year med student for eternity), a third-year medical student is practically in pull-ups (u^u). We think that we are big enough |(~^~)|, we have our "own patients" (☉ ~ ☉), you have your [short (¬_¬)] white coat \ (•~•) /, and can even walk in epic slow motion (¬■_■) (after or before duty hours)Yet, deep down we know that yes, even though the majority of med students have the books, question banks and medical material tattooed in our brains(¬_¬), this is practically the equivalent of being equipped with a butter knife and thrown in the most dangerous Indiana Jones -Tomb Raider Adventure you can think off ^_ (¬~¬) _ /.

In other words, making our patients endure my pre-round test would bring no benefit because I was at the training stage where I hear all weird chest sound (Yeah like the heartbeat and normal breathing? (¬ o¬)) or when there is something really going on (sounds like a Metallica concert inside the patient's chest (-u-)) but you hear "normal" chest sound (¬_(_)_). However, I was sure of one thing, I would bring her an extra-round of pain by placing the stethoscope and trying to move her to the side in order to have access to her lungs. I spoke my concerns to my residents; I would have more than plenty of chances to learn Lung and Heart sounds in healthy and ill patients (.'_'). but I felt that I was just causing harm because my competency level was not yet par to par to make any clinical diagnosis (¬^¬). And even if I had the full competency, either them or the attending would need to confirm my findings. The residents agreed to waive the patient from the pre-round, in fact, the residents decided that due to the circumstances, they would make one physical examination with the attending and minimize the physical checkup once a day, unless her clinical condition required more assessment. Our attending agreed with the plan (◦●_●◦).

It would be a Happy Ending if I stopped the story here and claimed that the futility concept was solved (¬(¬o¬)¬). That I just shielded myself with the futility term and waived my pre-round in this pre-text, when in fact what I did was a balancing of harm and benefit principles. Nonetheless, futility was just in the corner waiting to ambush us again (¬'_¬).

A few days passed, and our patient started to deteriorate. She was on IV and topical antibiotic but was not responding. She continued to slough her skin, the sheets needed to be constantly changed due to blood and pus stains shed day and night. Her folded skin emitted a putrid odor...I felt she was decaying while alive. No capacity, no advanced directive, no designated health proxy. Oxygen saturations levels reaching dangerous levels, her physical examinations were not improving either...our patient was crashing. In a matter of days or hours she would be in cardiac arrest(ಁ_ಁ).

"The team believes that doing CPR is futile" -explained the senior resident of the team, to two out of the three offsprings.

"You are giving up." - accused the youngest. He looked at each of the members of the team. "She is my mom!" he exclaimed.

"We know that this is difficult."

"No, you don't" - interrupted the youngest, but the older of the two, placed a hand on his shoulder. The room fell quiet. My residents had a serious, neutral expression, the one that we are trained to wear...The sons, they were mortified; however, the eldest was the one with more control, his face unreadable.

"What is the plan?" – the eldest asked, his voiced calm and soft.

"We don't think CPR, resuscitation, would be beneficial for your mother... We will keep her in comfort, but if her heart stops, we are not going to do anything."

I remember the long pause that followed that sentence. Neither of the siblings uttered a word. The youngest had a fierce gaze, the eldest was prompting the team to go on with the plan...that was the plan.

"We need you to sign the DNR (Do not resuscitate)-"

"No." - interrupted the eldest.

The resident remained quiet.

"We will not sign; you will do everything possible to save our mother. We will speak this with our eldest sister. In the meantime, keep our mother alive."

We were in a deadlock. Our attending wanted the DNR paper signed, the team firmly believed that performing CPR would be causing more harm than good, and 2 out of 3 siblings were vehemently refusing DNR...no advanced directive, no health proxy and a deteriorating patient.

Eventually our patient crashed(☹_☹), and the full code was activated. The code was successful...I think...almost two years later, I still remember the conflicting emotions I felt after witnessing the code (._.). Our patient end up on a ventilator and high sedative, the skin on her chest was completely destroyed...CPR is a very rough intervention, it is not the fancy and chic TV version where almost everyone survives, or spontaneously wakes up to confess their undying love to their savior(¬_¬)....this is real life CPR.

Dr. Jennings gave an *Ethics for Lunch Seminar* at Bayview regarding this misperception. During the lecture, I learned that CPR was labelled by Safar in 1975 as an intervention “To challenge death anywhere”, and since then the notion has taken root. I also learned that in 1968, Dr. W. Symmers emphasized the “Not allowed to die” concept...Which delivered us to the question “Should we always try to defeat death?” What about futility? If it is medically futile it would not make any sense. Nonetheless, the problem is when we try to measure probabilistic futility.

Another term that comes into play is *futility*. If the concept of CPR was mind-blowing, futility is just crazy (@_@). First there is debate in the definition, and then there is even more debate in the proper application to each case (>>.<<) . Brauch Brody and Amir Halevy makes three categories of futility: physiological, brain-dead patient as paradigmatic case of futility, and qualitative futility²³. Based on Brody and Halevy, Clark and Mikus expanded from these categories into the four new ethical analysis; which are Physiological, Imminent-Demise, Lethal-Condition, and Qualitative Futility²⁴. Physiological is defined as “an intervention that fails to achieve their intended physiological effect”²⁴. Meanwhile, Imminent-Demise is defined as “treatments carried out despite that the patient will die in the near future”²⁴. Lethal-Condition is “a treatment given to a patient with an underlying lethal condition, and said treatment cannot affect the results”²⁴. Lastly, Qualitative is defined as “a treatment that fails to lead to an acceptable quality of life for the patient”²⁴.

From the four definitions, physiological futility is the one that would be understandable to deny right away, just like it is justified denying medical intervention that would not address the disease (i.e. breaking a bone to focus the pain in the leg, and thus, alleviating migraine ($u \wedge u$)). However, this works in theory but during practice it is challenging (@o@). First, in most of the cases, medicine faces uncertainty...seldom in cases can clinicians be sure that they have reached an end. Furthermore, the other “futility” comes into play. For example, would the two minutes in between CPR be important for the patient, if they have a chance to wait and say goodbye for a loved one? It all depends in the circumstance of each case ($\smile \wedge \smile$).

This delivers us to our second and last point of the futility-CPR discussion: What is the medical profession’s role? $\neg (\bullet _ \bullet)$ Is it tasked with preserving life, prolonging life, mitigating diseases, preventing harm... all of them are loaded terms? $\neg _ (\odot \wedge \odot) _ /$ Note that preventing disease and preventing harm are not the same. A fair amount of my MBE thesis is dedicated to the physician role...the AMA Code talks about incompatibility with healer role, but what is a healer? $\neg (. \bullet _ \bullet)$ What is a curer? $\neg (. \bullet _ \bullet)$ Is a physician obligated or permitted to act beyond these two roles? $\neg (\neg _ \neg)$ This is important because it will help determine many medical interventions. My thesis addressed physician assisted death (also known as physician assisted suicide) but determining the medical profession’s role is also important for the CPR-futility discussion. In other words, what are our expectation with CPR? $\neg (\bullet _ \bullet ;) /$

At first, it resonates with the historical label, “shoo” death away from people (☹️). A more epic concept is to bring people back from the death “resuscitation” (•_•). Yet, if this were to be the purpose of CPR, then it would not be permissible to stop (o_O). A second that we could “shoo” death away, is a second that we owe to our patient (>>.<<). Therefore, if we do not perform CPR, then we are infringing the Justice Principle and Non-maleficence by not allowing the same opportunity to have another second in life. This is absurd! (ಠ_ಠ) First, because we are ignoring that the act of CPR in itself is also harmful (ಠ_ಠ). CPR is a strenuous and invasive intervention \ (ಠ_ಠ) /. This is not the two soft chest pushes, a tender mouth-to-mouth respiration, the dramatic eyelash fluttering, (•̀•́) three coughs with a little bit of water and then the romantic kiss between the two protagonists “Oh darling, you risk your life for me” cliché (ಠ_ಠ). The real CPR is a chaotic (yet organized) event, ribs are constantly broken, bruises are formed, potent chemicals are injected into your veins, there may be some electro-shock or there may be a tube trying to bypass the air into your lungs ...anything necessary to restart your heart (ಁ_ಁ). In sum, CPR should not be provided lightly, there is also a responsibility to not provide CPR. The harms and benefits should be weighed, and that is when futility comes into play. Furthermore, the patient’s and family’s values are important...the scenarios are not easy for the family nor for the healthcare team (ಠ_ಠ)/||.

After the full code, the team met once again with the family, this time with the three siblings. When we entered the room, they were around her mother, talking to her ...the youngest was holding her hand, carefully not to aggravate the skin around it (◡_◡). Our patient was deeply sedated, their only answer was the steady sound of the ventilator. The team explained that cardiac arrest would more likely occur soon. And once again, the team believed that performing the full code was causing more harm and suffering to their mother.

“We want you to do everything. We brought her *here* for you to save her, not to give up on her. She is strong” – said the eldest sibling, the middle one nodded in support, the youngest just kept glaring at the team. The DNR was not signed and the team was obligated to perform the full code when the patient crashed once again. That day was my last day on the Internal Medicine Ward Service.

For this case in particular, I think that the first CPR was ethically permissible, just like not performing it. This may be a little bit confusing at first (ಠ_ಠ). At the time of the first CPR, the prognosis was a little bit uncertain...it looked poor, but we were not certain. From a medical perspective, CPR did not seem quite efficient either. Therefore, if the family decided not to pursue CPR and provide comfort care, it would be ethically permissible. On the other hand, for the second attempt CPR may not even be ethically permissible. At that time the uncertainty level decreased, her health was quickly deteriorating, and CPR would continue to cause more harm than the possible

benefit the patient may have received. Signing the DNR would also be correct, from my ethical analysis. When CPR is no longer a medical indication (i.e. performing CPR in a dead brain patient), then there is an ethical obligation to not perform CPR. The team needs to communicate the decision with the family and help them cope with the new scenario. Of course, this should not be made based in the clinician's standpoint of whether it would be "worth the shot" at life, but under an ethical approach (=).

During the MBE we were introduced to multiple ethical analytical tools. One of them is the four-box quadrant method which was adapted from Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical* ²⁵. This method helps to lay down all the important facts necessary for an ethical analysis. Johns Hopkins has a unique approach that combines the 4-box with a series of questions:

STEPWISE APPROACH FOR ADDRESSING ETHICAL ISSUES

[Prior the first CPR]

1. What is your concern? Why does this case bother you?
Should the team withhold CPR against family wishes? My worries are patient's interest and autonomy, inflicting harm and futility.
2. Is this ethics: does this concern arise from conflict between moral obligation or other important values?
Although the case may have legal implications, there is an ethical concern.
 - a. What are the moral obligations?
The moral obligations are [1] inflict no harm to the patient, [2] provide effective medical intervention, [3] respect patient's values and autonomy.
 - b. Are there competing moral obligations?
Patient's values are unknown, and patient lacks capacity. Next to kin desires to continue aggressive intervention such as CPR. The medical team believes that performing CPR or other aggressive intervention is causing harm and no benefit to the patient.
3. What are the facts of the case? (SEE 4-BOX APPROACH) Do we need additional information?
 - a. Who are the moral agents or stakeholders?
Healthcare team, patient, patient's family, hospital, country (due to state of emergency and limiting resources).
 - b. Who gets to participate in identifying and defining the relevant values, principles, duties and moral facts?
Healthcare team and patient's family (due that patient does not has capacity). In case patient recover capacity, it would be the patient.
 - c. What do you, as the provider, bring to the table?
Medical expertise, comfort care, diagnostic explanation.
4. Are there other sources of information that can provide guidance or help resolve issue?
 - a. Paradigm case: More helpful c/d
 - b. Case law or professional guidelines: More helpful c/d
 - c. Helpful literature on this ethics issues
Schneiderman, Lawrence J., Nancy S. Jecker, and Albert R. Jonsen. "Medical futility: its meaning and ethical implications." *Annals of internal medicine* 112.12 (1990): 949-954.

Persad, G., Wertheimer, A., & Emanuel, E. J. (2009). Principles for allocation of scarce medical interventions. *The Lancet*, 373(9661), 423-431.
 - d. Other ethics framework besides the four principles (i.e. virtue theory)

Social Justice, Principles for allocation of scarce medical intervention (due to state of emergency).

5. What actions will be taken?

a. What choices are *possible*?

Provide CPR, not provide CPR, Discharge and transfer.

i. What are the advantages and/or disadvantages of each?

Discharge/Transfer: Patient is not medically optimized for discharge nor transfer.

Provide CPR: Family wishes are met, death is delayed | Patient's wishes unknown, inflicting harm, may not be medically indicated.

Don't Provide CPR: Do not inflict damage, do not perform intervention that may not be medically indicated | Family wishes are not met, patient's wishes unknown.

b. What should be done?

CPR should not be provided if there is no medical benefit to the patient.

i. Is there a choice that is preferable and is that what should be done?

Not providing CPR is preferable because this action does not inflict harm. However, the team should provide CPR at least at this current point. The team should educate the family and continue to re-evaluate the patient to determine whether CPR continues to be medically indicated.

c. What can we do?

Not provide CPR + provide comfort of care and education

Provide CPR + provide comfort of care and education

i. Take into account impediments to choices in "should"

Regardless of the CPR choice, comfort care and education to family about prognosis should be done.

d. What will we do?

Provide CPR and continue to re-evaluate patient, if health deteriorates to the point that CPR is not medically recommended, the team should not perform CPR. The team should continue to educate the patient's caretaker regarding the prognosis, benefit, and risk of CPR. Continue comfort care and adequate pain management. Explore other emotional/spiritual support (i.e. chaplaincy service).

THE 4-TOPIC METHOD TO APPROACHING AND ANALYZING ETHICS CASE

<p style="text-align: center;">Medical Indications (Principles: Promote welfare, avoid harm)</p> <p>Consider</p> <ol style="list-style-type: none"> What is the patient's medical problem? History? Diagnosis? Prognosis? Severe total body skin sloughing; skin infection complication. Alzheimer, cardiovascular disease. Poor prognosis. Is the problem acute? Chronic? Critical? Emergent? Reversible? Skin: Acute Critical Maybe Reversible Alzheimer: Chronic Nor reversible Cardiovascular: Chronic Not reversible What are the goals of treatment? Skin: Continue antibiotic; discover reason of skin sloughing, stop skin sloughing. Alzheimer: Comfort Cardiovascular: Continue medication. What are the probabilities of success? Skin: Medium-Low. CPR: Low; deteriorating prognosis. What are the therapeutic failures? CPR when not medically indicated. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided? The patient may benefit from comfort care, harm can be avoided by not performing unnecessary intervention. 	<p style="text-align: center;">Patient Preference (Principles: Respect for Autonomy)</p> <p>Consider</p> <ol style="list-style-type: none"> Does the patient have decision making capacity? If so, identify preferences. No If without capacity, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? Unknown, but it seems that the next to kin are using their own values as reference. Has the patient/surrogate been informed of benefits and risk, indicated understanding and given consent? Yes, surrogate have been informed of benefits and risks. They indicated understanding and gave explicit consent to perform a full code. Has the patient made advance care plans or named a health care agent? No. In sum is the patient's right to choose being respected to the extent possible in ethics and law? Unknown. Patient did not have capacity since the point of admission. Currently, family's wishes are being respected to provide full code.
<p style="text-align: center;">Quality of Life* Patient's Perspective (Principles: Beneficence, Non-maleficence, Respect for Autonomy)</p> <p>Consider</p> <ol style="list-style-type: none"> What are the prospects, with or without treatment, for a return to normal life? If skin condition is treated, patient can potentially return to her basal status. Without CPR, patient will die; with CPR patient may delay death. What physical, mental, and social deficit is the patient likely to experience if treatment succeeds? Patient has advanced Alzheimer; however, poor oxygenation period may worsen mental condition. Patient may have skin scarring due to skin condition. Is the patient's present or future condition such that his or her continued life might be judged undesirable? There is a high probability that the patient's health continues deteriorating, needing multiples full codes without health improvement. Is there any plan and rationale to forgo treatment? Yes. CPR intervention is too aggressive, causing the patient harm and little to no benefit. Patient's medical prognosis is very poor. Are there plans for comfort and palliative care? Yes. 	<p style="text-align: center;">Contextual Features (Principles: Justice; Values: Loyalty & Fairness)</p> <p>Consider</p> <ol style="list-style-type: none"> Are there issues that might influence treatment decisions? <ol style="list-style-type: none"> Family: Perceive healthcare team as "giving up". They want everything for their mother. Provider: Moral distress by inflicting harm to the patient. External pressure due to Hurricane Maria. Cultural/Religion: Unknown to influence. Financial: Not an issue in this case. Are there limits on confidentiality? Not on this case. Patient has no capacity, next to kin are making decision. Are there problems of resource allocation? Although not affecting this case specifically. Overall, there were resources shortages due to Hurricane Maria. How does the law affect treatment decisions? Healthcare team is also worried about legal consequences if CPR is not provided. Is clinical research or teaching involved? Not research. Teaching is involved because medical students and residents are in the team, but this is not a teaching case. Is there any conflict of interest on the part of the providers or the institution? No (that I am aware of).

Death is a Kaleidoscope

Chapter 9

Kaleidoscope. Death along with the dying process is simple yet complex ($\sim _ \sim$). It is simple because practically everyone is going to die, that is a fact ($_ _$). We don't when, where, with or how, but the moment we enter into existence our inner clock is ticking backwards (very insightful ($\neg \circ \neg$)). Yet, such simple event is surrounded by multilayer complexity ($@ \circ @$): cultural, social, economic, religious, personal, science, among others... Furthermore, it is an event of separation from loved ones, and a stage of the unknown ($\neg \wedge \neg$). Cassell describes the distress of imagining oneself non-existent²¹.

Linked to death and the dying process, we find other strong components such as suffering, pain, dignity, control, etc. As much as Medicine tries to claim to be objective and hold tightly to the hard-core Natural Science ($\sim \sim \nabla \sim$)~ all of these previous terms paint Medicine in a kaleidoscopic way. Until 2019, unless proven otherwise, gravity is gravity (☺☺☺), regardless of cultural, social, economic, religious [blah, blah and blah] complexities ($\bullet \bullet \bullet$)... If I drop an apple on Earth, it will go down ($\neg \wedge \neg$)/. I cannot say the same for medicine.

Theater of War brought a production at Hopkins about end of life. They discussed death and suffering through the play of Greek tragedies, such as *Philoctetes* and the *Women of Trachis* (☹️'∪'☹️). Well known heroes such as Hercules and Philoctetes at their dead bed, begging for *mercy* is an excellent icebreaker to start a discussion about death and end of life care in medicine. If you are a hardcore fan about Greek mythology (not the Disney version where Hera loves his “son” Hercules and Hades had pitiful attempts to conquer Olympus) (o_O), it causes a great impact. We are talking about Hercules, the one that beat up Hera’s challenges, walked the Hades to ask for Cerberus, the favored son of Zeus, who upgraded his demigod status to full god, reduced to screaming and crying, begging for mercy to his son, to end his misery...I will not spoil how he got into that predicament though (¬.¬). The art of a well-done theater (☹️'∪'☹️) is that the actors portrayed such angst feeling that there is no need for hardcore background. As you may suspect, this was one of my best experience: Medicine, Ethics and Mythology (my favorite pastime) \ (~ o ~) /.

These are potential activities that could be incorporated in the medical curriculum. A theater play of such caliber followed by an open-mic discussion. It helps to recognize the boundaries, challenges and struggle each of us as an individual encounter when thinking about death; but also, like we perceive death as healthcare professionals (i.e. failure) \ (• _ •) /.

The first step is to recognize that death is a natural and unavoidable process —(x_x)→. It is also important to recognized that even if an expected stage of all living organism, it remains distressful for those currently at the “precipitating” dying process^s and all of those surrounding them (love ones, healthcare team, etc.) (☹_☹). As professionals we sometimes do not stop to recognize such events. The fast pace required, the uneasiness of speaking about the topic are a few of the challenges to make an adequate debrief. My experience during Hurricane María was loaded with death, death that under “normal” circumstances would not have happened. I don’t recall a time we stopped-stopped to talk about the death of one of our patients. We were aware, we were shaken by it...but we needed to go on (*^*) ...we needed to stabilize the country (☹_☹). We passed from being the only tertiary hospital in the island to The Hospital in the island.

At Bayview, an Ethics for Lunch was dedicated to *Grieving*. It was led by the Ethics Committee and the Chaplaincy service (◡●◡●). During the hour, we were introduced to the topic of Grieving as professionals, and the need to recognize and be aware that the death of our patients affects us as an individual, as team and to the care of future patients as well. It was advised that teams should debrief and talk about how

^s I added precipitated because practically everyone is in a constant dying process. However, most of the time when we refer to the “dying process” we mean those people that are critically sick and that their disease progression is irreversible and have a shorter time to live²⁵.

they feel after losing their patients (ⁿ_ⁿ). I think this is helpful and promotes a healthier work environment.

Soft meditation music and aromatic candles helped in the session (♥.♥). Furthermore, we were asked to write a poem about an experience where we lost a patient. It was very therapeutic (☹_☹). They asked us to think about our patient, that our mind and heart wandered back in time, and that we transformed the experience and feelings into a poem (ⁿ_ⁿ). Afterwards, we were prompt to share our experience and/or poems with the rest of the group. It was very refreshing and reassuring.

Don't Stop

The usual hallway.
White and cold.
Filled with systematic sound.
Artificial breathing around.

It wasn't until midday.
A new and yet unknown;
A sad desperate, but yet expected.
The sorrow of a family filled the hall.

We have lost a patient once again.
Bittersweet moment, predictable, nonetheless.
Yet, the same event, was still unique.
Different faces, different voices, but the feelings
felt pretty much the same.

Have a deep breath, record it in
Your mind and heart, but not be detained.
There are still people counting on us.
The fight is still not over.

We must proceed and fight.
 Avoid more losses.
 That was the motto
 For us all.

The second step is to recognize our limitations as individuals and the limitations of our medical profession (☉ワ☉). Life prolongation and death avoidance are desirable outcomes; however, those are not necessary the roles of the medical profession (☹_☹). During my thesis research, I needed to know what entitled to be a healer, a curer (•_•). I found out the concept of the battlefield approach (☿☹☿), where physicians struggle against disease and death, and the patient is just the battlefield where this colossal clash occurs²⁶⁻²⁸. I even found my favorite analogy by Cassell (♥☹♥), where he portrays the physician showdown with death through Nordic mythology, by comparing the physician to Thor in the wrestling match with Elli (old age)²¹ †. As weird as it may sound, the medical profession needs a healthier relationship with death (-__-). Again, this is challenging (ノ☉ワ☉)ノ, because unlike gravity, medicine is painted by all the factors mentioned before; making it difficult to standardized a chain of reaction and approaches.

Although death is a serious and hard topic. There is another outcome that concerns me...a permanent harm that does not results in death. A harm that patients will endure for the rest of their lives. Granted, physicians cannot ensure the desired

† *The Tales of Utgard Loki.*

outcome $\lceil (\bullet_ \bullet) \rceil$. However, physicians are responsible to maximize patients' chances. Besides the medical knowledge, there are two other factors that need to be mastered by the individual physician: recognizing one's own limitation and communication skills $(\circ \bullet _ \bullet \circ)$.

Recognizing Limitations Leads to Communication

Chapter 10

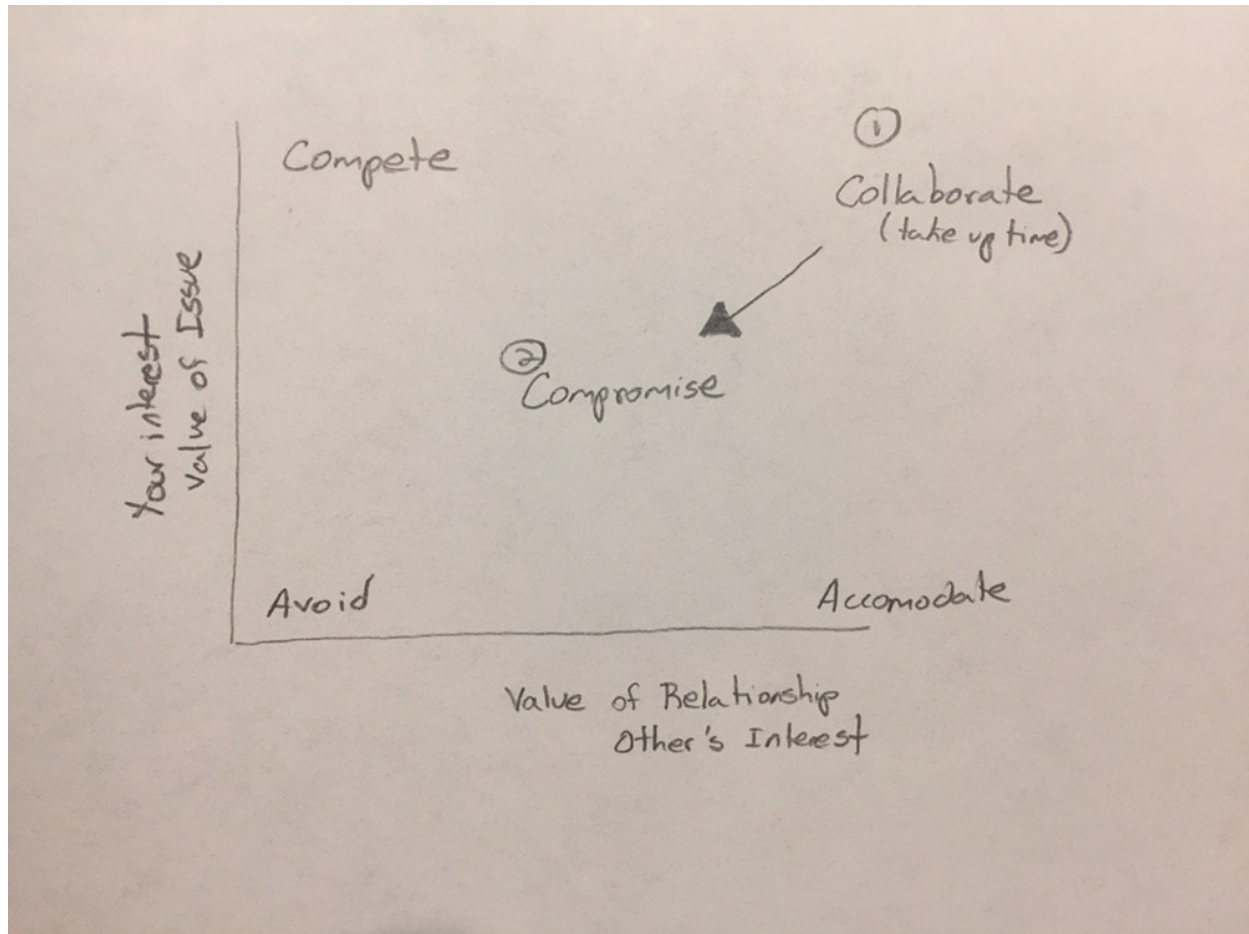
Physicians do not always cure nor always heal (✕ ∩ ✕). Nor do we control what is going to happen, we could lock anyone in the safest room in the whole world, yet death always slips through ∩ (. ‘ _ ‘.) ∩. Recognizing our individual and professional limitations is beyond just sulking in our mortality (#¬.¬)/.

There was an Ethics Teaching: *Conflict Session* with the surgery residents {•••}. I was expecting a session about physician-research conflict. However, I was in for a surprise...the conflict session was tailored towards intra- and inter-team conflict (°.°). Ranging from disagreement of medical opinions, duty, responsibility, among others. Different approaches were also addressed “Avoidance, Accommodation, Compromise, Compensation and Collaboration”. Each approach was measured in the value of relationship-other’s interest, one’s interest and the time-effort consumption. Now, I am going to share something very personal with you all (ʒ^~^ʒ), my **REAL-TIME**

UNEDITED, LIMITED EDITION GRAPH \ (^ O ^) / that I copied WITH MY OWN

HANDS (no, with the neighbor's hand (¬o¬)) from the whiteboard. Such a piece of art!

\(¬¬).



Trust me! Do you know the effort I had to put in that handwriting to be legible?

(¬¬). Look at the bright side the lines and the arrow are on spot (¬¬)\(¬¬). So, no need to recertify in legible writing... Pft...thanks that I will use from now on electronic record

مرحبا. أ.أ.ع

Anyway (☹️_☹️)...The ideal relationship would be to collaborate 24/7, but it takes up too much time. Time is the everyday problem, especially because diseases and our fragile mortality never seem to care to wait for at least one second (¬ o ¬). The second option would be to compromise. Interesting enough there are some situations that it are better to avoid, or to accommodate and maybe compete (i.e. compete for the best interest of your patient) ...*it all depends* (☺️^☺️).

Recall the patient that was not responding to anticoagulant in Chapter 3? (@_@) The lecture triggered a memory of a patient that I had a few weeks before that event. I was into the fourth clerkship of the year, I felt more confident. Still, I felt the butterfly in my stomach when facing a new challenge (♥️☺️♥️). The hospital was not like it was before, the ripple effect of María was still around. Introductions were made, patients assigned, and MS3's were deployed to their respective patients (r_■_■) /.

My patient was chatting with his family, cracking jokes. I introduced myself and made the history and physical exam. By that time, I still had not mastered the focus history and exam, which meant that the expected USMLE Step 2 CS 10-minute interaction was far far away (˘ ˇ ˘). I learned about his hobbies, about future plans in the year, the family's experience with the Hurricane. The family was concerned with the team's decision of withholding the anticoagulants, and the risk of clot formation. I explained that due to his recent fall, the team had decided to withhold the anticoagulant, preventing bleeding into his brain.

Neurology and Cardiology were consulted again. It was a stalemate. There were two options: to start anticoagulation or delay it. Both actions had big risk and benefit. If we started anticoagulation, we would protect against an ischemic stroke, but most likely cause a hemorrhagic stroke. On the other hand, if we delayed anticoagulation, we would protect for a hemorrhagic stroke, but most likely, an ischemic stroke could happen. It was a long discussion; everyone had the guidelines, lab tests, radiologic tests and research on the table; everyone was thinking what the next best step in management would be. Afterwards, I went to the Dark Room, as we used to call it. And made again a “consult” with radiology. After having all the information, and balancing all benefits, harms and risks; the team reached a decision.

It was afternoon, everyone was stable (^o-), it was time to sit down and make the notes, check for labs or radiological results. On lucky days (very rare) we would have time to even review course material or *USMLE STEP 2 CK* material (••). The pager beeped (o_o)...I continued writing but aware and ready to take on the new task, if needed.

“It is Mr. C, he is having a stroke.” – announced grimly our resident (‘_’). I felt numb, I had just talked to him a few hours ago(._.). I was currently writing his note, a perfect Neurological Exam...I stood up and followed my residents. The family was outside the room, nursing personnel were already with the patient. It was a massive stroke...

The team had multiple conversations afterwards. Should we have started the anticoagulant sooner, and taken the risk of a hemorrhagic stroke? (ಁ_ಁ) Were we too conservative in our approach? But then...if we ultimately decided to anticoagulate him sooner, and he had a hemorrhagic stroke, what then? (ಁ_ಁ;) Eventually, he was transferred to the ICU and unfortunately did not regain consciousness during the length of my rotation...

Unlike my first two rotations, I was expecting the unexpected...because everything was grossly out of place (= _ =). This did not mean that the other rotations were under normal conditions, but at least they were not under the active Hurricane María disaster scope. Looking back, the risk of a stroke was very high in our patient, it should have been something that I should have expected (. _ .). Part of the profession is to be aware of the risks surrounding our patients. Physicians should not make only plan A, but also have Plan B and C and so on, which responds to the expected and unexpected (~ _ ~).

Returning to the Ethics lecture, we learned that by being aware of our limitations as physicians, we are prone to enhance our communication and teamwork \ (• _ •) /. In our case, the Internal-Medicine Team was very open in communication; we had the insight of Neurology, Cardiology and Radiology Team which were actively sought and present (☉ _ ☉). Two of the consulting teams had conflict, paradoxically, with the same goal: the **best** patient outcome. Everyone was concerned with the patient's overall

health. What I am sure of, is that our patient would have had the worst outcome if the Internal-Medicine Team had not consulted or dismissed the Cardiology, Neurology and Radiology recommendations (•_•).

Opioids

Chapter 11

A short Chapter title, yet it says and means a lot. The Berman Institute hosts a seminar series throughout the year about Ethics. Early during my first MBE year, there was one about Opioids. I was intrigued, what was wrong with Opioids? Sure, they were mu-receptor agonist, strong pain meds, for pain like 8-10 (whatever that means), highly sought by patients (i.e. drug seeking behavior), but an ethical dilemma with them? YES!!!! \(\^{\circ}\text{O}^{\circ}\)/ Even my short opioid description shouts Ethical Emergency Disaster!

After the seminar, I realized there were serious ethical problems surrounding Opioids (☹_☹). However, I realized a worse problem (; _ _)...I had no idea how to prescribe them ^\(\^{\circ}\text{o}\)/. Ironically, little is taught at Medical Schools about pain and opioids around the USA. My school was no exception to the rule and I barely recall an hour or so of lecture during second (*was it third year*)? \(\cdot_ \cdot\). My take home message was something around the lines like: "*Pain is very very bad, Opioids are very very bad also, don't use them unless the pain is very very strong....and beware of the symptoms that plague opioids- the Drug Seeking Behavior [dun dun dun]" (☹_☹). I guess the curriculum back then swung towards Opioid prohibition. This phenomenon has been discussed in*

the scientific literature and recently was addressed by the AMA, regarding the importance to train their physicians amidst the opioid epidemic²⁹. It is challenging to approach pain, because it is subjective, and something tasked to be alleviated and/or eradicated (☹️). Pain leads to suffering...the issue is not whether or not we should address pain (‘-’), the issue is how to address something that you cannot objectively quantify (‘••’).

Luckily, that was not my last exposure to Opioids (☹️). It is very hard not to talk about them when your program director is an expert in the topic (XD). Later, during the Summer of my first MBE year, the book *In Pain* was released. The book is about a philosopher and ethicist by training who had a dreadful experience with opioids after having a motor vehicle accident that almost cost him his foot³. The book is an interesting mixture between a patient’s narrative, but at the same time, a scholarly work about the opioid epidemic (👍👍).

Practically, I had a conversation with the whole book. Dr. Rieder compares his interaction with the young physician (who took the time to know more about his patient) vs. the attending. The question that bumped into my head was: “Why?” (‘••’) Was it because the attending had a different personality than the young physician? ☹️.☹️ Or was the attending once like the young physician? (@_@). The book also had an in-depth discussion about the pain experience, making it a unique patient’s perspective. I won’t spoil my mentor’s book (☹️), but as a medical student, it gave me

insight that I would have gathered maybe in 30 years, ... maybe never (>_<). First, I would need to be exposed, then have the same patient, and then have the ability to know my patient's story from starting point to ending point...this is virtually impossible (⊙_⊙'). That is why narrative medicine is important in the physician formation (˘˘).

The main points that I could take from the book were: [1] We are in an opioid epidemic (˘_˘), [2] physicians are contributors to the opioid epidemic (f_˘)/, [3] responses toward epidemic are pendulum dependent (which mean that people are over-prescribed or under-prescribed, both equally evil (✕ ∩ ✕)), and lastly [4], there are currently abandoned patients suffering(˘_˘)....Oh! I forgot the fifth one, we are currently clueless in how to navigate addiction, dependence, and tolerance as one voice˘_˘_˘_˘/.

The question is what is my (and physicians-in-training) role amidst the opioid epidemic \(\text{XO}\text{X}\)/. The former CDC director Thomas Frieden noticed that “if the prescription overdose epidemic is doctor-driven [...] then it can be reversed in part by doctor's action”³. Physicians encounter a serious dilemma within the opioid epidemic: the duty to relieve suffering, but also to comply with their oath to avoid harm³.

(⊙⊙)(⊙_⊙)(⊙⊙)However, there is little consensus \(\text{˘_˘}\) in the methods of teaching medical ethics¹¹. Lucey and Souba recognized that educational strategies that aid in mindfulness, structured reflection, help physicians to respond to ethical and

professionalism challenges⁴. They also recognized that it is easier to mold the learning behavior in the controlled environment offered by medical schools, rather than change the behavior of a million independent physicians³⁰. (ಠ_ಠ)

How could we address this? (ಠ_ಠ) Currently, US medical schools offer less than 0.3% hours of pain management training to medical students³¹. Nonetheless, due to the exponential increase of new information, such as genetics, gathered during the last decades, the medical curriculum has increased its content (ಠ_ಠ). The timespan (4 years of training) remains the same (ಠ_ಠ). Consequently, we could expect that the time devoted for each topic decreases each time a new issue is addressed (ಠ_ಠ). Therefore, it is necessary to implement effective methods that accomplish the goal for the future professionals.

The complexity of the opioid's epidemic calls for medical students to be trained in the traditional branches of medicine such as physiology, pharmacology and pathophysiology (ಠ_ಠ); but also, in the ethics (ಠ_ಠ) of the opioid's crisis. Multiple authors recognize the importance of medical education regarding opioid prescription and how this could help mitigate the mortality and morbidity toll in the United States.

Narrative has been used as a tool in ethics education (ಠ_ಠ), such as *The Use of Force* by William Carlos Williams and *Brute* by Richard Selzer. Unlike *The Use of Force* and *Brute*; *In Pain* is written from a patient's perspective, who at the same time, is a

philosopher and bioethicist. Dr. Rieder's book is described as a "gripping personal account [...] but also a groundbreaking exploration of the opioid epidemic"³.

Pharmacodynamics and pharmacokinetics of opioids can be memorized by heart (■L■), but , compassion, empathy, and critical analysis most likely are achieved by experience (ㄅㄆㄇㄏㄏㄏㄏ).

Narrative allows trainees to have an experience, although not perfect, through the eyes of another person (ö.ó). The advantage is that Narrative allows the student to recognize ethical dilemmas, errors that could be applied in real cases. Requesting a medical student to read a 250-page book (×_×#) would be surreal (and evil) (-^~). However, selected text provides the necessary narration to stir a critical analysis regarding the ethical dilemma and challenges that medical professional should consider when faced with the opioid crisis....

As of now, I am working on an Op-Ed which hopefully will be out there very soon \ (OoO) /. The topic is more about the need to add Ethical Opioid Prescription proposed by Dr. Rieder. My second project is about a specific patient population that had been affected by physician prescription and a possible method to tackle the problem. In other words, I have a lot to do in the first half of year 2020 and before graduation in May \ (^o^) /. The take home message from this chapter is that we as professionals need more awareness of the consequences of our actions (*^*). In my case, as a caterpillar \ (-o-) / , to learn and think what else can be done to [1] mitigate the

opioid epidemic (s^") and [2] avoid other similar 'epidemish' damage $\mathfrak{C}(\partial_{\sim})\mathfrak{D}$ by
 being more perceptive of the domino effect after the clinical encounter $\geq \odot_{\sim} \leq$.

Continuity until The End

1992 – hopefully not tomorrow

Chapter n-1

“Did you notice? (*^*)”

“Notice what?”

“That! (#¬,¬)”

“...”

“\(^-^)/ Sometimes, you had emoji deficiency”. (ノ ㊦ 益 ㊦)ノ 彡 ㄣ ㄣ

“Aaaaaand, you think is *immoral, unethical*? Am I half *Wall-e* now? (¬.—)”.

No, I do not think I have a problem <(。 _。)>...I just wanted to portray or *tried* to portray a transcendental conversation with my caterpillar self \ (ツ) / . Yes, emojis sometimes decreased, the seriousness of each encounter increased, responsibilities increased \ (‘ _ ‘) / . In other words, experiences (hopefully) push towards change, but is a butterfly worse than a caterpillar? ¬_ (ツ) _ / Is it better? Well *it depends* (¬_¬). A more challenging question is a butterfly any different than the caterpillar or is it just an

enhanced caterpillar with wings? (☼.☼) I am not going to abuse my now-favorite answer(¬_¬).

Now that I am almost finished with my MBE and little dues are waiting for the fourth year ☼(¬■_■)♪ I feel that I can have a glimpse through my chrysalid. The world looks different. In fact, I bet it looked different when I was a zygote! \(-o-)/What I mean is that there is nothing new at all with the sensation. Every single day, every second, experiences are hitting like meteor showers. It is in fact what tells you that you are alive...interactions, situations, decisions (◡_◡_◡).

Although change is expected and until a few seconds, appraised, we also need consistency in one's self (¬_¬). It would be very bizarre to create and maintain long term relationships, if everyone drastically changes per encountered experiences ¬_(_o_o_)/. A few standard deviations from my 4-year-old self, a few less than my teenager self, and so on (@o@) . Just to pick up someone randomly, I don't think that 2-years old Adolph Hitler contemplated being remembered as the protagonist of one of the highest crimes towards mankind ☼(ò_ó~☼) .

At the other extreme, imagine a person at his 50s, still driving and behaving like an uncontrollable teenager \ (◡_◡) / . This only means that change in itself does not hold a moral value (☼.☼). Instead, it is the recipient to hold accountable for accepting, ignoring and/or internalizing such changes(u_u). Although, as interesting as it may sound, this is a topic for another time \ (•_•) / .

As of today, here is the answer I can bring to all those *Robocop* believers (#¬¬)/.

Yes, medical school causes changes (☹☹), because the physician formation is filled with different and impactful experiences ☹(ò_ó)☹. And quite frankly, there is no way that a caterpillar can survive ¬(¬¬)¬, the field is not made for caterpillars (hence the need of training) ¬_XX●_XX_/¬. However, this is not the equivalent of a worm transplant (■L■), the caterpillar is the same, and it is expected that the little cute worm, grows the required wings (with a few enhancements as needed) (~▽~). At the same time, as a med student, the professional formation is arduous; burn out, moral distress, fatigue, non-mature defense mechanisms are assaulting you at every corner ¬(☹☹)¬. Consider those as gamma radiation ☹(ò.ó)☹...without the proper protection and guidance...a mutant butterfly could be created (☹__☹) or maybe complete abortion of the caterpillar and butterfly altogether (¬¬) (we only need to check the high suicide incidence in the physician community).

Such a dark turn this reading took (x.x). Blame my MBE mentor, one of his specialty is in the ethics of climate change and the opioid epidemic (^o^). Now that emoji is odd, bioethicists understand the emoji dilemma (¬¬)...Anyway, on a lighter note, what about me? (/●ㄣ●)/*:° ✧ ✧° ∴* \ (●ㄣ● \) Well, I consider myself closer to the butterfly than the caterpillar, although now I visualize lots of butterfly stages \ (°¬°) / (You know like *Barbie Fairytopia* stuff, she develops new sets of wings per movie or something along those lines) (づ。●__●。)づ. My learning in life is a

continuum...I have a core, which is the *Me-myself-I*, but until my last breath, I will be in constant exposure with circumstances, decisions, etc. $\neg _ (\text{ツ}) _ /$ Which will (hopefully) prompt the required changes for life...some people called it aging, others maturity $(\bullet _ \bullet \clubsuit)$.

What I am sure of, is that I don't want to forget this process $\text{ㄣ}(\text{!} \cup \text{!} \text{ㄣ})$ because if I have been aware of it.... I can potentially create a better butterfly. This way I can pick up the best moments from the stages during my formation $(\text{ㄣ} \text{ } ^3 \text{ }) \text{ㄣ}$, understand reactions or gut feelings $\text{ㄣ}(\neg \blacksquare _ \blacksquare) / \text{♪}$, but most importantly discard unacceptable behavior $(\bullet \circ \bullet) \text{‡}$. For all of this, I need to be conscious of my process, I cannot forget how from caterpillar I turned into a butterfly $(\text{ㄣ} _ \text{ㄣ})$. I am not the only one to share this belief, Mount suggests that students keep a journal/portfolio documenting their emotional reactions, insights and questions relating to their evolving clinical experience, in the manner described by Charon³². I believe this is true $(\neg \blacksquare _ \blacksquare)$. Although it is not practical to keep written track of all the encounters, it is an excellent exercise for medical students $\text{ㄣ}(\neg _ \text{ } \neg \text{ }) \text{ㄣ}$. I hope that my experience compilation adds useful information to our healthcare community $(\bullet _ \bullet \clubsuit)$. That throughout time, people can relate and hold a conversation with this text that breaks time and space $(/ \bullet \text{ } \text{ } \bullet) / * : \cdot ^\circ \text{ } \spadesuit$.

If you asked me prior and during med-school- pre-MBE era, "What do you want to be when you grow up?" $(\bullet _ \bullet)$ I would have given a very concrete detailed answer. Something like a medical doctor specialized in the third molecule array of the $\frac{1}{2}$ of the

upper ¾ left lung only nodule(¬■_■). Today, the answer is still very concrete but radically different~(˘▼˘~). My answer to that question today is that I want to be a *droplet* when I grow up. I will give two clues for this (¬_¬). The first is a place, the second a well-known motto.

- A pond.

- *"Protecting Health, Saving Lives – Millions at a Time"* - Johns Hopkins School of Public Health

No, I am not evil, (☹_☹) a little bit mischievous perhaps (^o^). I am just making you part of my current present (●_●✿). I am also, playing *Sherlock Holmes*, preparing letters of intent, making a list of residency programs, and wondering where I will be in the next 10 years \(*0*)/. Okay let's be realistic, I am wondering more often where I will be in the next 2 years ^_(_)/. Anyway, I digress...soon I will be 100% butterfly (currently 75% butterfly, 25% caterpillar) (¬_¬); just like every stage in life, it is a ¼ certainty, ¼ mystery, ¼ mystical and ¼ unknown (— —'). Time will tell! (๑•_•๑) In the meantime, I am very excited for these last two terms of the MBE(๐_๐๐๐). It looks very interesting ^_(¬■_■)/ ♪.

๐(ò_ó~✿) Until we meet again (๓ ๖๒๓)(be it in person or through another text) take care and go forward in your life \(^o^)/, leave a good mark in your timeline! \ (^o^)/

¡Hasta luego! (^o_)/

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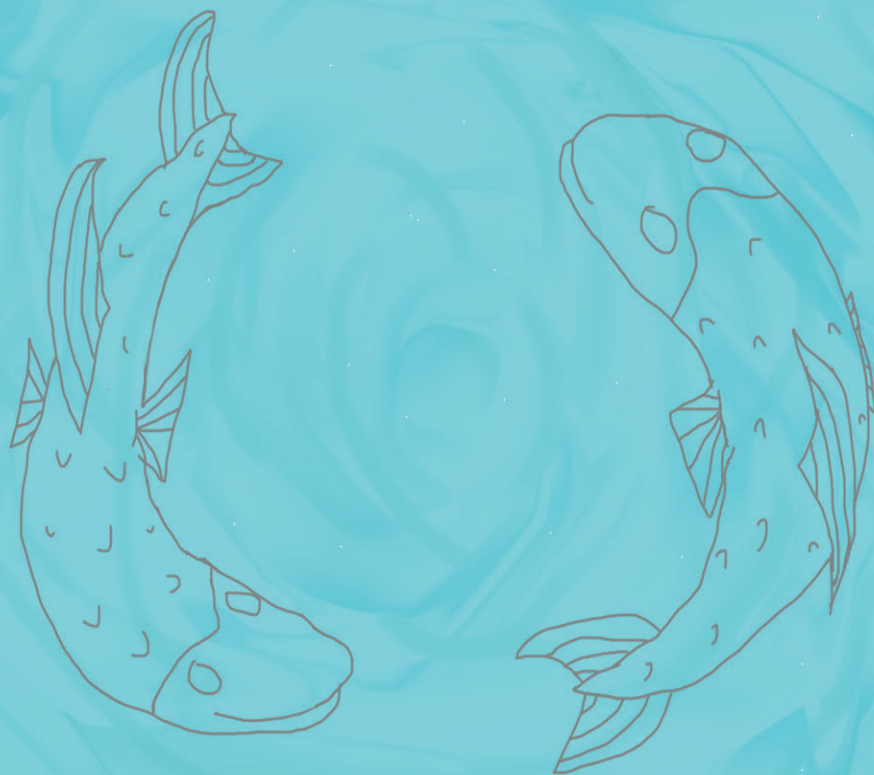
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Appendix 1: Citation Addendum, Chapter 1

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