

Trainee-Authored Letters to the Editor

Deconstructing Bias

To the Editor: I had a relatively easy childhood, one built upon a foundation of financial stability and access to resources that felt more like rights than privileges. My first clinical rotation, pediatrics, thrust me into family situations that challenged this simplistic idea of “normal.”

My first patient on outpatient pediatrics was Bryan, a 4-month-old who presented with hypertension. Chart review revealed he was born 14 weeks premature after his mom was in a car accident. His mom reported heavy alcohol use during her pregnancy. I tensed up—how dare she knowingly endanger her child? My anger subsided, replaced by confusion. Was I being a naïve, privileged medical student? “[Child Protective Services] was called, they took care of it,” my resident noted. Took care of it? Did CPS somehow undo the permanent damage this mother did to her newborn?

Within minutes, I had formed a number of presumptions about the family. Bryan—textbook fetal alcohol syndrome. Dad—not in the picture. Mom—an alcoholic, overweight and disheveled, unlikely to adhere to any care plan we deliver.

I entered the room, simultaneously unsure and so sure of what to expect. Bryan was swaddled in a blanket, content. His mom was mildly overweight, neatly dressed, and did not smell of alcohol. A well-equipped diaper bag was on the seat to her left. The image I had built was shattered.

During Bryan’s blood draw, his mom laughed, “Bryan’s dad owes me, I hate holding this guy down for needles!” *Bryan’s dad*. Even with this concrete evidence of his involvement in Bryan’s life, I had trouble placing him in my mental image of this family.

I left that encounter upset with myself for quickly forming opinions based on one line in a chart. I had never been challenged in such a way—to walk into a patient’s room acknowledging alcohol use during pregnancy, CPS encounters, and my doubt in someone’s ability to be a “good” parent. After comparing what was written in the chart with the family I saw in that room, I

realized I had inappropriately allowed my bias to speak for the patient.

The clinical years are special because they present trainees with many opportunities to discover and address such implicit biases. With this perspective, I began to approach each patient as a new “first”—to see them for who they *are* rather than the words in their chart. And each “first” has prepared me to better serve future patients without preconceived notions. To provide personalized care free from destructive bias. To help patients thrive.

Author’s Note: The name and identifying information in this letter have been changed to protect the identity of the individuals described.

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Hannah E. Kay

Third-year medical student, University of Texas at Austin Dell Medical School, Austin, Texas; Hannah.Kay@utexas.edu.

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My First Rotation ... Above the Arctic Circle

To the Editor: “When someone invites you to hunt, you *never* be late.” The Iñupiaq elder’s words rang in my ears as I tugged a second pair of jeans on over my first. I barreled out of my tent and onto the 16-foot aluminum Jon boat, barely on time and hardly prepared for the next 6 hours of scouring the Ambler River for moose—or if it was Nature’s will—bear. The white fish’s scales hardened that week, a subtle preamble to the return of winter, making the success of subsistence hunting trips increasingly important for surviving another season of snow and ice.

I spent the 5 weeks between my first and second years of medical school in Alaska’s Northwest Arctic Borough, taking bush planes from one remote village to the next with a doctor who has served these communities for her entire medical career. Officially, I was there to conduct sports physicals for the village children; unofficially, I was there as a sounding board for the doctor as she weaved Iñupiaq culture, Western medicine, and tribal dynamics into each patient’s care plan.

This was my first medical rotation. It was the first time I tasted words like

“lisinopril” and “metoprolol” roll off my lips, each as new to me as the *muktuq* (beluga blubber) and *tuttu* (caribou) I was offered during patient home visits. While antihypertensives followed me on my journey back to the lower 48 states, certain experiences will forever be unique to the arctic tundra—unless patients in Michigan ask me to join them in picking blueberries, felling trees, or filleting salmon.

In isolation, these Arctic experiences are fond memories and great stories, but in context, they tell the story of the medicine I provided. Combatting hyperlipidemia and hypertension included discussions about cutting back on seal oil while preparing beluga and how spicing caribou stew with wild herbs is a healthy alternative to using salt. We treated chronic back pain with ibuprofen, an ice pack, and some extra strength Tylenol, but also talked with our patients about new ways to bend while picking blueberries and how to engage their core while mushing dogs.

In my first medical rotation, I learned that caring for my patients starts with understanding who they are. While I didn’t see many zebra diagnoses, I did help hunt for the village moose.

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Kevin McCawley

Second-year medical student, University of Michigan Medical School, Ann Arbor, Michigan; kwmccawl@med.umich.edu; Twitter: @kevin_mccawley.

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Subhanallah: A Cultural Connection

To the Editor: I notice Khaled’s father tapping away at his phone as the ultrasound technician images his son’s diseased arm. I pass it off as mere distraction.

I am meeting Khaled today because his right arm suddenly became tender and swollen. His life is dictated by a rare vascular disorder that has ravaged him and left him with painful venous malformations throughout his entire body. Years of malformations have turned his arm into an edematous trunk. Today, it is violaceous, and Khaled winces in pain when I so much as brush my fingers across his skin to check for warmth.

Khaled and his father are from Saudi Arabia, and by virtue of Khaled's needs, both moved to Baltimore a few years ago. With no friends, family, or fluency in English, daily life here is a struggle. Yet this experience, as isolating as it may be, is the best hope they have for Khaled.

As the ultrasound technician continues her work, I take a closer look at Khaled's father. Strangely, his phone displays a single number, and every time his finger meets the screen, the number advances. Rhythmically, he taps the screen. 31. Tap. 32. Tap. 33. Tap.

I suddenly recall breaking my leg when I was 6 and seeing my mother frantically rush from the kitchen to tend to me. Later that evening, in the waiting room of the emergency department, she pulled out her prayer beads and counted them one by one. "Subhanallah," she whispered, as her fingers reached for the next bead. "Subhanallah," she whispered.

"Subhanallah," I whisper, as I see Khaled's father tap the screen. His cadence matches my mother's perfectly. Instantly, I recognize his act is not one of distraction but one of deep love and devotion. Khaled's father has been in lockstep with his son this entire time.

This was my first cultural connection in medicine. I was granted an innate understanding of Khaled, his father, and their journey. It gave me the lens to properly interpret distraction as love. Reflecting on the experience, I recognize the need for a health care workforce that better represents the backgrounds and experiences of our patients.

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Bilal A. Bari

MD-PhD Student, Johns Hopkins University School of Medicine, Baltimore, Maryland; bbari1@jhmi.edu; Twitter: @bari_bilal; ORCID: <https://orcid.org/0000-0002-8381-3802>.

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Taking Time as a Student to Connect With Patients

To the Editor: In one memorable patient encounter on my first shift in the emergency department (ED), a gentleman in his 80s presented at 2:00

AM with difficulty urinating due to an enlarged prostate. As I walked to his room, I thought through my laundry list of questions, determined to keep the conversation focused. I introduced myself, sat down, and began. "When did this start? Has this happened before?" And so on. Between my targeted questions, he mentioned joining the Marines during the Vietnam War instead of going to medical school. I took a pause; as a veteran myself, this was always an excellent way to connect with a patient. He told me about his service, that he still thinks about the friends he lost, and that he lies awake at night hearing gunfire. He recalled one of the scariest moments of his life when he was on a helicopter taking incoming rounds and had to autorotate to safety. I told him I served in the Army as a helicopter pilot, and I knew how scary that situation must have been.

I looked down at my watch and noticed the date, April 6, 2019, 14 years to the day when I lost my comrades in a helicopter crash in Afghanistan. I paused again, and, instead of rushing to the physical exam, I told him about the helicopter we lost, Windy25. We shared war stories and remembered friendships forged in combat. I do not remember how long I was in his room, but when he left later that morning, he winked and said, "Thanks, Captain." We found an extraordinary connection in our similar experiences.

As I have reflected on this encounter, I realized what a unique position I was in as a medical student. Patients from all walks of life come to the ED, vulnerable and with an implicit trust in people they do not know. The elderly Marine put his trust in me, and I had the luxury, as a student, to pause, listen, and answer to no one except the human being in the hospital bed willing to share his most intimate life story with me. Taking that extra time helped me realize the power I had to create meaningful and healing encounters not only for my patient but for me as well.

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Brooke Hergert

Third-year medical student, Dell Medical School, University of Texas at Austin, Austin, Texas; brooke.hergert@utexas.edu; Twitter: @BHergert; ORCID: <http://orcid.org/0000-0002-2041-7618>.

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Sharing Identities for the First Time

To the Editor: Clinical experiences during preclinical training carry an extra glimmer of excitement and meaning with a select few serving as dazzling reinforcement of my decision to become a physician.

"I have a medical student with me today. May she join us?" Consent received. I enter the room to join my preceptor and perform as much of the history and physical as I can—given my level of training. It is a well-rehearsed dance, expectations fulfilled, experience gained. But then the dance changes.

"I have a medical student with me today, may she join us?" Consent received. I enter the room, grabbing the rims of my wheels as I push my wheelchair forward and come face-to-face with a patient seated in a wheelchair of his own.

"Oh wow!" He exclaims, looking me up and down while excitedly checking out my ride. This is the first time I have worked with a patient who shares my wheelchair-using identity. We engage in a thoughtful and productive conversation as I take his history; he smiles throughout.

My preceptor and I leave the room as the appointment ends, and she pauses as the door closes. "You know, Sam, the way that patient looked at you—that's the same look I get when my patients realize their doctor is also African American. It's a look you don't forget; it reminds you why you need to be here."

Though this experience was certainly a first for me, it was also a first for my patient. Increasing diversity in medicine needs to extend beyond the lines of gender and race to encompass identities like disability. Approximately 56.7 million Americans have disabilities, and this population is recognized to experience significant barriers in receiving health care.¹ Yet, a recent study suggests that only 4.6% of medical students disclose having a disability.²

The significant discord between the patient population we, as future physicians, will serve and current diversity of trainees deserves and requires