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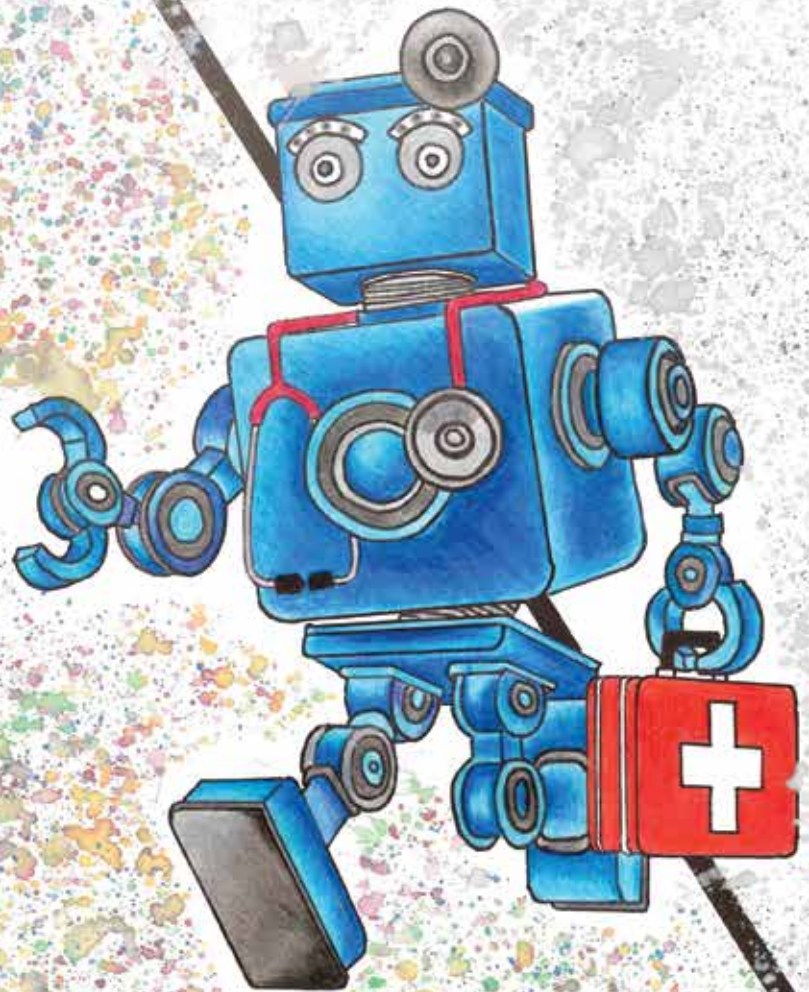
ISSUE HIGHLIGHTS

Where is medicine headed?

Reflecting on our experiences

Interview with Dr. Eveline Hitti

AUBFM NEWSLETTER
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Fatima Chamseddine

EDITOR IN CHIEF MESSAGE

Sarah Jamali

I proudly welcome you to Radioactive's 5th volume! Radioactive has served as a platform for information-sharing and self-expression among healthcare professionals at AUBMC since 2013 and has provided them the opportunity to delve into topics they feel passionately about, the ones that they believe are worth sharing with others.

Thanks to the dedication of our board members and the loyalty of our readers, this newsletter is now the largest it has ever been. This issue explores a myriad of subjects, including but not limited to palliative care, mental health, healthcare policies, alternative medicine, the future of certain medical specialties, and more. Also included are reflective articles that challenge the unidimensional perception of physicians, as well as book recommendations that have deeply touched faculty members.

I sincerely hope that you enjoy flipping through its pages and that you will learn something new while reading it, be it about yourselves or about the medical field.

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Designed by the Department of Communications and Public Relations, AUBMC

AUBMC'S MEDICAL ARTS FESTIVAL

Sarah Jamali & Raji Naamani
Editor in Chief and Associate Editor

The first annual Medical Arts Festival took place outside Saab Medical Library on October 7, 2017. It was a lively celebration of creativity and various talents on campus, meant to honor the medical school and commemorate AUBFM's 150th anniversary.

Thanks to the efforts of medical students, faculty, and staff, a scene was set to bring the artistic side of our field alive. The festival fostered open discussions across disciplines as guests gathered at the site to admire the display of artistic skills. The crowd reveled in the sights and sounds, with a stage that attracted a wide range of audience, delicious catering by Souk el Tayeb, and exhibits of fresh talent in the form of vivid paintings, powerful photographs, and delicate sculptures. The event even had a dedicated section for children's entertainment, and the vibrant schedule included a healthy dose of competition with a Jeopardy game between students, residents, and physicians.

A variety of performances took the stage throughout the day, featuring exquisite piano recitals, inspirational spoken word poetry, and vocals that brought chills to the audience. These acts continued into the night with the musical talent of several Lebanese artists and groups such as Postcards, Flugen and Loopstache. There were also the bands Waynick that included AUB medical students and Generations in which AUBMC's very own Dr. Kamal Badr played his guitar, supporting this event every step of the way. Dr. Badr said, "It is very important for people to tap into their artistic, humanistic side to keep it alive and sensitized. This helps further improve the way a healthcare team interacts with patients."

Rawan Safa, a Med IV student and one of the event organizers said, "It was great to see everyone out of the hospital environment, expressing their different talents. We had a thorough line-up of musicians, dancers, artists, all sharing their love for AUBFM. I was amazed by everyone's artistic and human side, and it was amazing to see that this side is present when caring for patients!"

For many, the value of the day was in recognizing the importance and relevance of integrating arts into medicine. It was a night to remember as the crowds danced to music that faded up into the night's sky.



THE DODO BIRD OF MEDICINE

By Nadeem Bilani
Med 3

Medical specialties pass in and out of style, fashioned by technological innovation, evolving patient demographics and the politics of healthcare. But is it possible for one to go extinct? Vinod Khosla – Indian-American engineer and billionaire – claims the role of radiologists will be “obsolete” in five years.

In an article published in CNBC this year, Khosla explains that tech companies are developing software that uses sophisticated algorithms to study images like X-rays and CT scans. He asserts that computers could use this artificial intelligence (AI) to identify abnormalities in scans more rapidly and accurately than a radiologist could [1].

AUBMC’s own associate professor and infectious diseases (ID) specialist, Dr. Zeina Kanafani, highlights transitions in her field too. Despite the increased power of “serological and molecular methodologies” in diagnosing infections compared to older practices – i.e. culturing techniques – she and other ID specialists insist there remains a necessity to teach younger physicians-in-training these traditional skills.

Dr. Kanafani iterates a counterargument: “These advances serve to supplement rather than supplant the traditional practice of medicine.” For example, the programs would allow radiologists to triage hundreds of scans by priority before studying them manually themselves. But to what extent does this argument apply to technologies employing AI (which conceivably, could function independently of human operation)? Time will tell if physicians can continue to transcend the power of their own inventions.

The organizational climate of medicine today is one of specialization and sub-specialization. In many ways, it is also a contest. Patients can effectively shop for who they want to treat them and what therapies they prefer to try. This is because there is overlap in the different fields addressing the spectrum of human health and disease.

Nurse practitioners in the US can be licensed to diagnose and treat conditions like hypertension, diabetes, and coronary artery disease. As a workforce, they are expected to double in size by 2025 [2]. What about other up-and-comers on the healthcare scene? Some expect patients might refer less to psychiatrists if psychologists are armed with larger prescription powers. Interventional radiology has arisen as a renaissance, hybrid specialty tackling diseases previously addressed by general, vascular, and urology surgeons, amongst others.

Reality is unlikely to match Khosla’s radical claims. No major specialty in recent history has truly gone “extinct” despite some of the aforementioned waxing and waning forces at play. Nevertheless, I do believe it is paramount for medical students to, themselves, attempt to forecast the dynamicity of the medical playing field (i.e. through existing patterns in disease epidemiology and burgeoning vs. diminishing fields of research).

References:

1. Farr, C. (2017). Here’s why one tech investor thinks some doctors will be ‘obsolete’ in five years. Retrieved from <https://www.cnbc.com/2017/04/07/vinod-khosla-radiologists-obsolete-five-years.html>
2. Auerbach, D. (2012). “Will the NP Workforce Grow in the Future?: New Forecasts and Implications for Healthcare Delivery.” *Medical Care* 50(7): 606-610.

SELF-CARE VS. HEALTH-CARE

By Farah Allouch
Med 1

As medical students, stress and anxiety are not uncommon visitors in our everyday lives. In fact, some days, it seems like we have accepted these unwelcome guests as habitants, and each of us seems to deal with this unfortunate reality in different ways. Some develop unhealthy coping mechanisms such as overeating, binge drinking, avoidance and denial. These factors can become major contributors to burnout – a relentlessly hovering threat in the life of any medical student.

A recent 2017 study conducted at AUB found that a whopping 43% of its medical students test positive for burnout, 24% for depression, 23% for anxiety, and 14.5% for suicidal ideation¹. These statistics are shocking alone, but the reality may be even more alarming owing to the substantial stigma associated with mental health disorders in Lebanon. It is also worth noting that these rates were not significantly different across the 4 years of medical school. Another study cited that only 22% of medical students with depression were making use of mental health services. When asked for the main deterrents, 48% of students cited lack of time, 37% said lack of confidentiality, 30% mentioned stigma and 24% were afraid of documentation on academic records².

Most medical schools still employ an ad hoc approach to mental health in the best of cases, but advances are undeniably being made. For example, the University of Colorado established a 9,000 square meter Wellness Center which uses cutting-edge medical research to create an optimized, mental, physical and nutritional health program individualized for each student, and more universities across the US are following suit.

As 1st year medical students, over three months into arguably the most stressful time in our medical education, we have received one email reminding us of the mental health services provided to us as AUB students. Accounting for the daunting depression rate among medical students, this now warrants us more than just a mass email from the AUB administration. In a town hall meeting with first-year medical students, Dr. Ramzi Sabra, the assistant dean of medical education at AUBFM, informed us that the medical education committee and AUB are developing a program specialized in dealing with the mental health of AUB students.

Kudos to AUB for taking this initiative, which is truly indicative of its pioneering role in education and medicine in the Arab world. In the meantime, it seems crucial for AUBFM to advocate among its students the importance of seeking mental health care. This can be achieved through the Counseling Center in West Hall, where AUB students are entitled to unlimited and confidential appointments free of charge. Another step is to coordinate with other organizations to conduct engaging and beneficial mental health awareness campaigns specifically oriented towards medical students. At the end of the day, how are we to care for others if we cannot care for ourselves first?



Drawing by
Sara Catherine Mourani

References:

1. Talih, F., Daher, M., Daou, D., & Ajaltouni, J. (2018). Examining Burnout, Depression, and Attitudes Regarding Drug Use Among Lebanese Medical Students During the 4 Years of Medical School. *Academic Psychiatry*, 1-9.
2. Givens, J. L., & Tjia, J. (2002). Depressed medical students' use of mental health services and barriers to use. *Academic medicine*, 77(9), 918-921.

A DISORDER CUSTOM-TAILORED FOR MEDICAL STUDENTS

By Patrick Debs
Med 1

In my first few weeks of medical school, the biochemistry professor mentioned that a characteristic feature of Marfan syndrome is the ability to superimpose the thumb and little finger of one hand while encircling the wrist of the other. I decided to try and, to my surprise, I found out that my fingers superimpose very neatly. Instantaneously, I looked up this disorder. My professor's statement, coupled with the internet's immense power to convince you of your 'terminal illness', were sufficient for me to diagnose myself with Marfan Syndrome. From there on, I started noticing more signs and symptoms in my body and could not help but worry about how I will break the news to my family; my life expectancy may be shortened due to this connective tissue disorder that I have undoubtedly inherited. Little did I know that I was actually suffering from a much more common, yet less severe condition: Medical Students' Syndrome.

Medical Students' Syndrome is an acute form of hypochondriasis that generally affects students who are training to be physicians (as if we needed more problems to worry about). It describes a student's tendency to self-diagnose the diseases they learn about [1]. Medical students are continuously made aware of their bodies as they encounter a wide array of medical diseases, both in their textbooks and in the hospital setting. As such, it is very common for them to adopt the symptoms they are learning about and improperly diagnose themselves, especially after witnessing a traumatic or emotional experience in the line of work [1]. Evidence for this condition dates back to the 1960's when the first study on hypochondriasis in medical students was conducted and found that at least 70% of medical students suffer from phantom diseases ².

While current research aims at discrediting Medical Students' Syndrome as an actual disease ², it is fundamental for students to be aware of this tendency and the power of imagination they possess when it comes to evaluating the signs and symptoms of their bodies. Although this may seem humorous to many of you, it can potentially impact a student's ability to withstand the grueling years of medical training ¹.

And so fellow medical students, if you feel that you or anyone you know may have Medical Students' Syndrome, do not be afraid to seek help: this will lessen the already-heavy load on your white-coated shoulders.

References:

1. Collier, R. (2008). Imagined illnesses can cause real problems for medical students. *Canadian Medical Association Journal*, 178(7), 820-820. doi:10.1503/cmaj.080316
2. Waterman, L. Z., & Weinman, J. A. (2014). Medical student syndrome: fact or fiction? A cross-sectional study. *JRSM Open*, 5(2), 204253331351248. doi:10.1177/2042533313512480

OUT LOUD!



DO YOU THINK MEDICAL STUDENTS SYNDROME IS A REAL ISSUE FOR HEALTH PROFESSIONALS, AND HAS IT AFFECTED YOU IN ANY WAY?

A



“After only a module through medical school, I started to understand why older medical students told me “learning more is also worrying more”. After encountering the notion of sleep apnea in class, I started identifying some symptoms in myself: chronic fatigue, difficulty in concentration during the day, waking up with a headache... However, I would always say to myself that this is mostly because we try to make sense of the amount of information that we receive daily by trying to put ourselves in the patient’s shoes. What is more annoying is that I also started to think in my mind of pathological explanations every time a family member or a close friend of mine complains about something.”

Ghassan Bou Saba, Med I

A

“Among the many diseases I self-diagnosed during my two years of medical study, there was this one time I went to family medicine with a suspicion of anemia. Of course, it turned out completely baseless. You learn that just because there are a thousand ways the human body can go wrong, it doesn’t mean yours necessarily is at the moment. Then, you forget again. I was in family medicine two weeks ago for dyslipidemia. Want to take a wild guess to how that turned out?”

Firas Yatim, Med II



A



“I am sure that every medical student goes through a phase of excessive awareness of their health status and over analysis of minor symptoms they experience. However, I would not go as far as calling it a “syndrome”. I think this phenomenon manifests itself enough to cause debilitating anxiety only in predisposed students with baseline illness anxiety disorder or somatic symptom disorder: medical knowledge only sheds light on existing irrational fears and fosters preexisting worry.”

Elio Adib, Med III

BLASTS FROM THE PAST

By Karim Kozhaya
Med 2

- A book bound in the skin of an infamous criminal
- Sherlock Holmes
- The first medical school for women in Britain
- The specimen used to establish the association between coal dust inhalation and pneumoconiosis

Four seemingly unrelated items linked to the Surgeons' Hall Museums in Edinburgh. Home to the finest pathology collection in the UK, the museums retrace the unique contribution of Edinburgh to the modern day surgical practice – from cadaveric dissections to the discovery of chloroform as an anesthetic by James Young Simpson in 1847.

On exhibit, and of particular intrigue, are the exploits of Burke and Hare: the infamous duo who sold unclaimed bodies to Robert Knox, one of Britain's finest anatomists. The scarcity of corpses took them down the slippery slope of crime and murder. After selling fifteen of these corpses, the duo was caught; Burke was hung; his body was publicly dissected, and a piece of his skin was used to make the cover of a book on which is inscribed his execution date: January 28, 1829.

The museum also retraces the origins of arguably the most famous fictional detective: Sherlock Holmes. Best known as a prodigious writer, Sir Arthur Conan Doyle graduated from the Royal College of Surgeons of Edinburgh in 1885. As a medical student, Doyle met his professor Joseph Bell, credited to be the inspiration behind Sherlock Holmes. Bell was a master of logic, observation, deduction, and diagnosis. When he observed sailors' tattoos, he could tell where their travels had taken them. By inspecting his patients' hands, he could deduce their occupations. He could extract data about his patients before they even spoke, through mere observation.

Other interesting stories embedded in the walls of the university are those of the "Edinburgh Seven" - the first seven women to study medicine – and of the "Surgeons' Hall riot" – the male confrontation they faced on November 18, 1870. As hostility towards the Edinburgh Seven grew larger day by day, it culminated in over two hundred men harassing the seven ladies and blocking their way to class. Although the women were not allowed to graduate, this event was a defining moment in the fight for women's rights to study and practice medicine.

I do believe that a visit to the Surgeons' Hall Museums is a must for any medical practitioner, student, and aspiring physician. I had not considered visiting this museum as I was wandering through the streets of Edinburgh on my last day. Luckily, the erratic Scottish weather had other plans for me. Once rain began to fall, I sought shelter in the closest museum I could find. I spent the next two hours marveling at the intricate and complex history of medicine. Roaming through the museum's age-old halls, I was able to value the impact of some medical inventions and breakthroughs. I also had the chance to appreciate the different approaches to diseases throughout the ages, discover the forgotten realms of the practice, and fathom the evolution of this remarkable science.

INTERVIEW WITH DR. EVELINE HITTI

Q: How did you decide on your specialty?

H: I grew up hearing about the cases my father - a family physician - cared for and it was actually a lot of acute care. So when I went to medical school and started rotating I enjoyed everything but not to the point where I could see myself specialized beyond acute care. When I did my EM rotation I fell in love with it!

Q: What's the status of Emergency Medicine in Lebanon?

H: I'm very optimistic about it. What we have done through AUB's efforts and support for Emergency Medicine over the past 10 years, is what some other countries have accomplished in 30 years in terms of educational training programs, recognition of the specialty by "daman" and extending the model of EM care to other places through affiliations. Also, our graduates are going to play a role in advancing the specialty further.

Q: Do you see the field of EM changing in Lebanon?

H: Absolutely. There's still a lot of work to be done, for example on the EMS front and categorization of Emergency Departments in a centralized, coordinated way. We also need more academic departments of EM beyond AUB to help push the research agenda, grow the specialty and improve acute care across the country.

Q: What do you think is the greatest strength in our Emergency Department?

H: I think we have a special home at AUB that's been very supportive and that has been instrumental in driving us to where we are now. We also have a great team of nurses that have really partnered with us to make the changes that we were able to introduce.

Q: What is the biggest difficulty you have faced throughout your move back to AUB from abroad?

H: As a physician transitioning from the US to here, the biggest challenge was overcoming people's lack of trust in systems. Adjusting to that level of anxiety was a big challenge in moving here and finding ways to quickly build that trust with patients to take care of them effectively was a steep learning curve.

Q: Which profession other than your own would you like to attempt?

H: I like process engineering and operations management which is why I ended up doing an MBA. The MBA helped me approach problems from a system perspective and think of ways to introduce reliability to processes.

Q: Which profession other than your own would you never attempt?

H: Singing! You don't want to hear me sing.

Q: Why did you move here?

H: Family primarily. I also wanted to come back to a place where I felt like I could have impact.

Q: What do you miss most from the US?

H: Open green spaces and American brunches.

Q: What advice would you like to give medical students at AUBMC?

H: To really pick something they're passionate about because it's a long road ahead that requires increasing emotional energy once you become responsible for patients, their families and lives. So if you're not passionate about your specialty, it's hard to do well in that career path without passion driving you forward.

Q: Do you have any specific advice you'd like to give to female medical students?

H: Find partners that value equity at home as much as equity at work.

Q: Do you think our medical students are well-prepared for abroad, and what can we do to improve?

H: I think our medical students are very strong and are doing tremendously well abroad. One challenge is the fact that we are a small country, so exposure to uncommon pathology is limited. It's surmountable in certain ways, like by building centers of excellence. It's really important for students to just see as many cases as they possibly can, and not shy away from volume because that is one of the most important things to build experience and skill.

Q: What's something you enjoy doing in your spare time?

H: I like to read: mainly medical biographies and organizational psychology.

Q: What are some ways you think a doctor can make the most of their time with their family?

H: By trying to find protected family time where you are disconnected and present.

Q: What's your most memorable experience as a medical student?

H: Coming to AUB. When I was a med student, Dr. Huda Zreik, who was Dean of Health Sciences at AUB at the time, visited Hopkins and encouraged a few of us to come spend a summer at AUB in Health Sciences. It was my first exposure to AUB and left me open to coming back.

Q: Is there anything we haven't asked you that you'd like to tell our readers?

H: Always remember to integrate time for life because once you're an attending, 80% of your job is not going to be the technical medical; it's going to be connecting to people, their lives and helping them overcome their illnesses.



HEAL: A BEACON OF HOPE

Hussein Khachfe
Med 1

At a time when access to healthcare is clearly a necessity, we still struggle to provide such a basic and inalienable human right to those less fortunate, in Lebanon and globally. While AUBMC funds help provide social services to those who cannot afford modern healthcare costs, nonetheless some populations are still at a significant disadvantage.

This is where HEAL, one of the most ambitious student-led initiatives to date plays a role. HEAL is driven by the four pillars: Health, Empowerment, Advocacy, and Learning. Founded by a group of medical students with the vision of providing free healthcare to the underprivileged, HEAL primarily targets the health needs of migrant workers (domestic and construction workers) and is the sole Lebanese organization to do so.



Ahmad Chmaise, one of the founders of HEAL, said: "It all started off as a vision a group of us had during Med I. After a successful free medical day headed by Lama Assi, the thought of a sustainable health clinic targeted to migrant workers was born." It took just over a year to finalize all the necessary steps with the AUB administration. In June 2017, HEAL found its home in the Wassef and Souad Sawwaf building at AUBMC.

Here, every step of a patient's path is organized by volunteer students and nurses, under the supervision of physicians. The experience of HEAL volunteers extends beyond the clinical encounter, as they are required to consider every step within the sociocultural context of their patients. I had the opportunity to volunteer at HEAL in December 2017, and witnessed first-hand how a dedicated team made a tangible difference in patients' lives. Even the simplest of tasks brought us closer to our patients and reminded us of the core values of our field.

HEAL provides primary care services and continuity of care. Medical students and residents are able to follow-up with their patients, sometimes even in the outpatient department. They created a network of referral centers to help patients find affordable and accessible options for any further tests required. HEAL also hosts empowering health classes at the Migrant Community Center to cover a variety of important health topics, with a focus on practical preventive measures.

With over 230 patient visits in less than nine months, HEAL has proven to be a functioning initiative with the potential to flourish. It provides a platform for all of us who wish to further explore the humanitarian side of our profession as we prepare for our medical journeys.

Sara Farran, a core team member of HEAL stated: "Some people come to HEAL without having had a single blood test or medical checkup in over 15 years. Becoming aware of the presence of such people living among us is what made HEAL come to existence and what keeps us moving forward."



OUT LOUD!



HEAL IS NOW A REALITY, IT HAS A FULLY FUNCTIONING CLINIC AND VOLUNTEERS COMING IN AND OUT TO HELP. SO, WHAT DO YOU THINK IS NEXT FOR HEAL?

A



“We still need to reach out more to our target population; some patients still come to us months after their medical problems start because they didn't know about HEAL. We would also like to offer more specialized services, including screening services (with follow-up tests included). Finally, we must use the information we have about our patients' access to medical services in Lebanon to advocate for their right to better health insurance coverage.”

Lama Assi, Med III

A

“The sky is the limit. One year ago, this was nothing more than a dream. HEAL has extended a helping hand where there was none. It's astonishing what people can do when they put their hearts and minds into something, and through all the growing pains and inertia they've overcome, it's now clear that nothing can stop HEAL's cabinet and volunteers from achieving the highest of goals in serving the underprivileged.”



Alaa Kassir, Med II

A



“HEAL is the ultimate dream of a thriving medical student who aims to make an impact throughout his/her journey. Taking part in HEAL made me appreciate the amount of work and dedication its members have put into bringing HEAL to light and how much they cherish it. HEAL solidifies the prime objective of medicine as a profession through which we cater to patients without expecting anything in return. HEAL aims high at reaching out to the largest sum of people. It aims to deliver the basic requirements of a respectful society in which every person is given the chance to access medical resources and receive the proper treatment.”

Hadi Sabbagh, Med I

IT'S 3 AM AND IT FEELS LIKE HOME

Fares Sukhon
MD PGY 1

Walking through the hospital corridors at 3:00 am, I couldn't help but feel a sense of familiarity. This place has become home in certain ways, and it feels odd, almost unnatural, to feel at ease in a hospital.

Every morning, we get handed the names of strangers who have taken residence overnight in rooms that we've grown accustomed to. We know which rooms have the brightest lights shining through, which rooms feel stuffy, and which rooms hold a little piece of us inside them. If the walls could speak, we would hear the constant hum of people's stories clamoring on top of each other, sometimes delightful, but oftentimes dreary enough to feel their weight materialize across the confined spaces we refer to using mere numbers.

What baffles me, though, is how often we forget that hospitals are unhappy places. We tend to forget that people do not choose to be in hospitals but are rather forced to. We tend to forget that no one enjoys being pricked and prodded, only to be awakened at every hour of the night to answer the questions of a stranger disinterested in the contents of their dreams.

Sometimes we overreact; we speak in hushed voices behind closed doors about the overly zealous family or the patient who asks too many questions. We can't help but feel defensive when our actions are questioned; we are in disbelief when a patient argues back, and we are in awe when a patient distrusts our words. We sometimes seem to forget that given the unfamiliar setting of a hospital, the constantly changing staff shifts, the beeps and bellows of machines and other alien equipment, and the utter lack of sleep that sharpens any feelings of loneliness and frustration, it is incredible that most of our patients are understanding.

So we need to listen more and act less. We need to pull up the chair and sit down next to our patients when they're complaining, rather than tower over them with a presumed sense of righteousness. We need to understand their concerns, understand the position from which they're speaking, and behave accordingly. We need to smile more and reflect the image of the doctor we dreamed about. We need to make our patients feel at ease in this place we've long considered to be home.



Drawing by
Sara Catherine Mourani

“NOTHING ABOUT US, WITHOUT US”

Motto of the Disability Rights Movement

By Sarah Abi Raad

Med 2

Approaching a person with disability for the first time can be an intimidating experience. Out of fear of coming across as offensive or perhaps inappropriate, some would rather avoid the interaction altogether, only to perpetuate the fears and stereotypes.

One thing is for sure; this is not a topic we learn about in medical school. According to Academic Medicine, most medical schools in the US do not offer proper training in care for patients with special needs, as it is not a core curriculum requirement for accreditation or receipt of federal funding. Rather, disability is often viewed as an obstacle to overcome, and health care providers tend to disregard its social, emotional, and cultural contexts.

It follows, then, that this lack of competency is one of the most significant barriers that prevent these patients from receiving appropriate and effective healthcare [1]. An interesting paradox thereby arises; one study [2] reported that while some doctors may not take adequate account of the disability, others may tend to attribute everything to it, and, therefore, do not explore new complaints as thoroughly as they should. For instance, the assumption that a physically disabled person is also mentally compromised may lead to downplaying the importance of the patient's self-reported medical history. Likewise, a doctor may choose to turn a blind eye to the pelvic exam of a patient with a spinal cord injury, falsely assuming that the patient is not sexually active. Even worse, perceiving the quality of life of a disabled person as “poor anyway” may compromise patient care.

However, the WHO estimates that almost 15% of the world population lives with some sort of disability [3]. Regardless of your medical specialty, you will likely have a patient with disabilities presenting for a complaint unrelated to their condition during your career, and your preparedness, comfort, and knowledge regarding the issue will influence the quality of care you will provide. Thankfully, the profession is aware of this differential behavior, and an increasing body of medical schools have been developing new educational strategies to compassionately treat patients with disabilities. Including lectures on the social context of such patients, small group encounters with these patients and their families, and even OSCEs in which people with disabilities are trained to be standardized patients. Self-reports by medical students all agreed that early exposure to such a pool of patients helped them provide better care.

At AUB, the subject is yet to be tackled on the educational front. In Lebanon, there is still a long way to go before inclusion becomes second nature.

In the movie “I am Sam”, the main character, Sam, is an adult with a developmental disability. An initially insensitive attorney says to Sam:
I need that list of names from you – people who can testify that you're a good father despite your handicap. I didn't mean your handicap, I meant your disability [shakes her head] The fact that you're retarded. That's not the right word [exasperated] I don't know what to call you!
To which he replies: Sam. You can call me Sam.

References:

1. <https://www.ncd.gov/publications/2009/Sept302009#Overview>
2. Symons, McGuigan and Akl, 2009
3. http://www.who.int/disabilities/world_report/2011/report/en/

THE ART OF GIFTING STORMS

*By Sarah El Halabi
Med 4*

I invite you to walk with me through the internal medicine ward, a place where work is out and about, and rounds are never-ending. I invite you to join me, away from the educational and academic setting, on a short trip to that room at the end of the corridor where Mr. X is lying dyspneic. Mr. X does not know why he is dyspneic. He is angry and continually screaming at the medical staff. The other day, Mr. X made a sneering comment at a friend on service: "Patients leave this hospital as they come in." Try not to be insulted by his reprimanding of the management because Mr. X does not know he has metastatic cancer. He also does not know that his metastatic cancer is literally choking him to death. Mr. X's family believe they are doing all they can, protecting him from the fangs of this pernicious disease, and concealing crucial information from his worried mind. If he is going to die, their argument goes, why ought they overwhelm him with existential concerns?

It is not uncommon for families, particularly in our part of the world, to obscure information from relatives regarding the latter's medical conditions, especially when it comes to malignancy. On the other hand, we are taught time and time again, as part of our medical education, that patient autonomy supersedes all. The patient has the right to decide what to do with his/her body and with his/her disease. It puzzles us, therefore, why families choose to take medical decisions on behalf of competent and mature adults. It puzzles us further why they so very adamantly believe that impinging on someone's autonomy is a very wise decision. Sadly though, Mr. X is not the only example of such impingement. I have seen countless other patients live and die in agony – some after multiple procedures and chemotherapy, without being told why they were receiving all that invasive care.

The stigma surrounding cancer is sky high in Lebanon. Given that we have some of the highest rates of cancer in the Arab world and given the maliciousness of some cancers, it is understandable why the average person might want to conceal a cancer diagnosis from their relative. It is not acceptable, however, in my opinion, for us as healthcare professionals to be accomplices in this concealment. The cultural milieu, I understand, is not helpful for us to break bad news in the most direct of ways. Perhaps though, it is up to us to create a novel milieu. Perhaps, we need to lobby for patient rights, not as individual physicians but as a powerful adamant institution, until breaking bad news becomes the norm. Hopefully, people will ease into the idea of listening and discussing their fears openly. With time, people might become more accepting of the idea of being diagnosed with cancer. By and by, we might become experts at gifting storms.

UNDERNEATH THE WHITE COAT: FINDING THE PHYSICIAN WITHIN

by Dr. Zakia Dimassi
Faculty Member and Physician

"Humility is not thinking less of yourself, but thinking of yourself less."
C.S. Lewis

Can you recall the last time you had that indwelling sense of unease in your own field when put under the spotlight, and it wasn't out of false modesty, humbleness, or uncertainty in the face of an inherently complex problem? Notice that was not a yes/no question, because I have an inkling that you have, somewhere along the way. This phenomenon is dubbed "Imposter Syndrome" (IP). The entity was originally coined back in 1978 by two clinical psychologists (P. Clance and S. Imes), who happened to be, you guessed it right, women! The authors describe women who, despite evidence of high achievements both educationally and professionally, fail to internalize their success or acknowledge they are deserving of it.

What makes you more prone to IP? Perfectionism, for one. If you often grapple with self-defeating behaviors in the pursuit of perfectionism, then you are more likely to experience IP. Moreover, the roots of IP may be traced back to childhood and upbringing. Growing up in families where approval is granted for achievement but where feelings receive little validation can sprout a predilection to IP.

Doctors are inflected with such strong stereotypes of being upstanding, trustworthy, clever, and the worst of all, infallible². It is no surprise, then, that they are especially prone to IP. Henry Marsh, a neurosurgeon and author of the memoir *Do No Harm*, says: "Part of you knows you're not as good as you're pretending to be. But you have to come across as being relatively competent and confident." It is daunting to face patients who have an exaggerated perception of the power of modern medicine while you are cognizant of its many limitations – a knowledge that you keep to yourself, mainly because you must maintain the façade of the confident, competent caregiver.

Does it ring a bell? When you are alone in the patient room, reluctant about the next best step in management? We have all been there. The trick is knowing how to go about it without jeopardizing patient care, all the while striving for equanimity. There are two key steps in dodging IP. First, learn to embrace uncertainty in medicine, particularly in an era of explosion of knowledge amid a flood of white noise. Second, accept that we need not know everything. Accomplishing these steps requires a form of mentor-mentee rapport between senior doctors and newcomers. Physicians in training greatly benefit from the expertise of their senior colleagues. Notably, this exchange cannot proceed unless there is an established culture of safety, where seniors are not threatened by being open about their vulnerabilities. Blurring the lines of hierarchy between faculty and trainees is an equally powerful impetus that builds on the social aspect of the learning experience. Ultimately, honest exchange of experiences will harness "productive failures" as a normal component of the learning curve.

Reference:

1. P. Clance and S. Imes *Psychother. Theor. Res.*15, 241–247; 1978

2. Smith, D. E. (2003). *Making sense of what people do: A sociological perspective. Journal of Occupational Science* 10 (1): 64-67.

MAKING SENSE OF YOUR GOALS MIDST LIFE AND DEATH IN THE HOSPITAL

*By Sara Bitar
MSc Candidate*

Accomplishing certain endpoints in life is a constant critical chase, especially in the medical field, even if they are short-term or long-term goals, mundane or life-changing. Making sense of our aims is a difficult journey of its own; to discover and pursue what we truly want. Some days it is just that, but other days we are reminded of the unpredictability of death and it numbs our checklist like a an inevitable roadblock waiting there for us.

"Hello Lisa, how are we today?!"; you ask like the results in your hand mean nothing at all. You have come to know Lisa well by now, familiar with her case of stage 4 breast cancer, her stable BP levels, and her unchanging poor prognosis. That is not all you know about her; you know her hopes and dreams, how she wants to open her own pastry shop, marry that guy who says her croissants are the best he's ever had, and move to France once her business blooms. Lisa died that night, as did all those things you once knew about her; and all your goals in life (that are just as important as hers) got a reality check.

As I sought out answers from medical professionals who handled issues of life and death almost daily, I began to see that dealing with death is arguably the most difficult part of the profession. However, I do believe there is a light somewhere in the distance. If you are certain that you have tried your best, then even if you fail, the next best step is undoubtedly to look forward and seek people in need with even more exuberance.

I do not promise solace or answers in my words, but for what it is worth, I can offer tips. Baby steps are key; if fear is the number one obstacle, then fear of the future is what limits us. Small tangible goals keep us in check; they do not shatter quickly in the face of doubt and uncertainty. Tip number two, which is simple but often neglected, is to remember why you started in the first place: "Why medical school? What can you offer? Where will it take you?" A third tip is to make sure you give yourself a break every now and then because burnout and stress are unspoken killers. One quote that stuck with me is "You didn't come this far to only come this far," and while life may seem like it is simply a waiting room to a foreseeable death, accepting that fact and turning it into an incentive will show you that the biggest motivation you need in life is life itself.

OBAMACARE: 8 YEARS LATER

By Anthony Gebran
Med 2

On March 23, 2010, Former President Barack Obama signed into law the Affordable Care Act (ACA), commonly known as Obamacare. This law aims at increasing the number of insured citizens by providing discounts on government-sponsored healthcare plans while also expanding Medicaid to cover more people who cannot afford healthcare. It also prevents insurers from denying coverage to patients with preexisting conditions such as Diabetes and Alzheimer's disease, and it mandates that the same rates apply to everyone regardless of previous medical history. Americans have the choice between 4 categories of coverage plans that range from Bronze to Platinum – Bronze being the cheapest but covering only 60% of costs vs. Platinum being the most expensive but covering 90% of costs.

Many Republicans challenged this law, highlighting the ever-rising premiums and arguing that the ACA does not do enough to cover all those in need. In 2016, repealing and replacing Obamacare became one of the central pillars of Donald Trump's presidential campaign. Despite winning the presidential elections, Republicans have repeatedly failed to do so, and it remains the law of the land for the time being.

As a medical student or resident planning to practice in the US, it is of interest to realize how your potential colleagues view the ACA. US physicians already saw that the top-down regulations governing their profession were excessive. For many, Obamacare only added to this frustration by expanding non-clinical duties and paperwork. Thus, many doctors who owned a private practice would have had to employ additional staff to deal with insurance companies and handle bills, while some even chose to abandon their private practices and join hospitals instead.

The financial aspect of the ACA is another concern for physicians. For primary care physicians (PCPs) working with patients who struggle to afford healthcare, the ACA is a double-edged sword. On the one hand, it made their job easier because most patients could now afford treatment, resulting in improved compliance. On the other hand, even the cheapest Obamacare plans have very high deductibles, which means that patients might have to pay up to \$6,000 before their insurance covers the remainder of their medical expenses. As a result, PCPs often have to deal with frustrated patients who believe that they are not fully receiving what they pay for in health coverage.

Perception of the ACA also appears to be influenced by the age of healthcare providers. According to surveys, medical students, residents and young physicians seem to have more favorable opinions of Obamacare compared to their older counterparts. While the former stress the government's role in assisting patients with lower incomes, the latter complain about the excessive and time-consuming paperwork that comes at the expense of their contact time with patients.

The ACA has proven to be a source of contention among physicians, but it is a step in the right direction towards a universal healthcare system that, one day, would guarantee coverage for all. Despite the progress achieved with Obamacare, it is clear that this law still needs major modifications to halt the rise in premiums and deductibles and reduce overregulation of the medical practice. Will this happen soon? Only time will tell...

WHY WASTE TIME SLEEPING WHEN YOU CAN STUDY?

Nour Makkaoui
Med 2

Twitching widened eyes with empty expressions are painted on the pale faces of medical students who may easily be mistaken for walking zombies. No, this sight is not from a horror movie, but rather is found outside examination rooms after a test; these walking zombies are the students who have not slept properly the night (or even the week) before. Usually, as the exam date creeps up on us medical students, we tend to scramble for study time without giving up on our procrastination rituals, of course. We, the students who study how important sleep is for our health and wellbeing, are ironically sacrificing it the most.

It's true that every student has their own study methods, and what works well for some may be detrimental to others. It's not surprising, then, that some students are able to sacrifice sleep time and manage their study habits around that, while others fall asleep from exhaustion and lose focus exponentially the fewer hours they sleep.

Despite the fact that sleep deprivation works for some students, research shows that staying up all night to study negatively affects focus, performance and even the person's long-term health outcomes [1]. It has been demonstrated that the sleep-deprived brain is more dysfunctional than the well-rested brain, and that sleep deprivation is associated with exaggerated emotions, reduced reaction time, and even impaired memory [2].

Staying up all night may not directly or visibly affect our grades, but it may have harmful effects on our physical, mental, and emotional wellbeing – especially in the long run. In the end, if we want to avoid having walking zombies around, we should try to evolve our study habits into a new form that doesn't involve us staying up all night.



Resources:

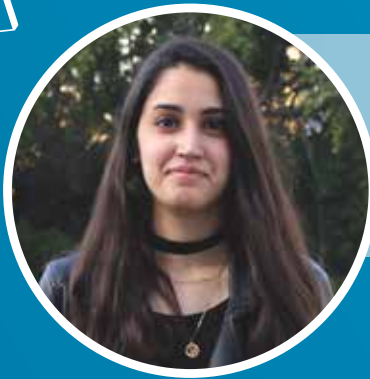
- 1. Effects of total Sleep deprivation on divided attention performance (2017), by Chua EC, Fang E., Gooley JJ.*
- 2. The Role of Sleep in Emotional Brain Function (2014), by Andrea N. Goldstein and Matthew P. Walker*

OUT LOUD!



HOW MANY HOURS OF SLEEP DO YOU USUALLY GET BEFORE AN EXAM, AND HOW DOES IT AFFECT YOUR FOCUS DURING?

A



“I get around 10 hours of sleep every day of the week before the exam, except the night right before, when I sleep for only around 6 hours. I get very tired during exams, and I absolutely think it’s because of the less amount of sleep I get.”

Amal Naji, Med II

A

“The week before an exam, I sleep my regular 6 hours a night. I spend the day before the exam efficiently studying, and I don’t sleep at all that night, except for a short 30-minute nap. I feel a little sleepy by morning, but during the exam I am just really focused and I don’t feel it anymore. So far this plan has been working perfectly for me, but I definitely do not recommend it for everyone.”

Bachir Ghandour, Med II



A



“I usually get a maximum of 5-6 hours of sleep before an exam. And that’s after a week of the same pattern and even less hours of sleep. It obviously has adverse effects on my focus during the exam. When I’m sleep deprived, I usually get a bit lightheaded and my legs and hands start shaking a bit.”

Ghina Al-Fout, Med I

ALTERNATIVE THOUGHTS ABOUT ALTERNATIVE MEDICINE

Sara Catherine Mourani
Med 2

From detox smoothies to colon cleanses, alternative medicine has taken over the minds of the masses with the recurrent promise of flushing out the ultimate evil: “toxins.” Countless health blogs wax lyrical about the benefits of basil or the different types of cancer that can be cured by patchouli oil.

Alternative medicine encompasses treatments that are used instead of conventional therapies, often with little scientific backing. It is baffling that, at a time when the internet provides such a wide breadth of information just a click away, we are seeing a new surge of support for alternative medicine. All of this begs the question: Why is this happening? Why now?

As doctors, we need to understand this shift in the mentality of our patients in order to thwart this wave of misinformation which can lead to potential dangers. According to Siahpush (2000), the issue can be analyzed from two perspectives: the individual level (micro) and the sociological level (macro).

One common reason for adopting an alternative lifestyle includes dissatisfaction with the traditional medical encounter. We are all familiar with the trope of the cold and detached doctor with a stronger focus on the disease rather than the patient. Some of this may be rooted in reality, but there is no denying the extreme dichotomization between traditional and holistic medicine. Siahpush (2000) argues that a “post-modern” value system has been established whereby nature and alternative medicine practices are associated with gentleness, caring and safety, while science, technology and conventional medicine are seen as rigid and cold.

Several societal factors play a role as well. Disease structure has changed considerably over the past century. Many diseases which were once major determinants of mortality are now controlled. The new actors on the stage are cancer and heart disease. Patient demographics have also changed; prolonged longevity comes at the expense of new diseases such as heart failure, dementia or chronic kidney disease. These require long, arduous, and psychologically taxing treatments. However, the medical profession still has not adequately matched this shift with one of its own.

The rise in popularity of alternative medicine is not something that can be written off as temporary folly of the masses. It is a public health matter. “Anti-vaxxers” are not vaccinating their children, and patients are being prescribed possibly detrimental treatments by unlicensed individuals. Taking a holistic approach to treatment is a necessary step towards regaining the trust of our patients whose diseases are as emotionally challenging as ever. The general public needs to understand that science is not the enemy of nature, and as Tim Minchin once said: “You know what they call alternative medicine that’s been proved to work? Medicine.”

Reference:

Siahpush, Muhamad. “A Critical Review of the Sociology of Alternative Medicine: Research on Users, Practitioners and the Orthodoxy.” *Health*, vol. 4, no. 2, 1 Apr. 2000, pp. 159–178., doi:<https://doi.org/10.1177/136345930000400201>.

REFLECTIONS: PROLONGING LIFE OR RELIEVING PAIN?

Samer Bou Karroum
Med 2

Why do we want to become doctors? What is it that originally motivated us to enter this profession? My personal answer was always: I am here to save lives. After all, this is what physicians do, isn't it?

The doctor's job of saving lives is cemented in every society's collective consciousness. It is even highlighted in the original Hippocratic Oath, which outlines how the sanctity of life must be preserved by doctors, regardless of the situation. It is time, however, for this perception to be reevaluated and challenged.

When it comes to my personal experience, the slogans about 'saving lives' that I once idolized have shattered. Two years ago, when I was a senior pre-medical student, my grandmother was diagnosed with liver cirrhosis. I started to read about my grandmother's disease and watched as one by one, the symptoms unfolded just as the books had described them. In addition, my grandmother also suffered from horrible side effects of the medications she was prescribed, and she was living in excruciating pain. My close relationship with her allowed me to set aside all the medical jargon and the apathetic tables, and this is what I saw: real life suffering. I followed up on my grandmother and her symptoms all the way to end, when she developed hepatic encephalopathy. The only stage to follow was death, and I realized she only had a few weeks left.

Being a traditional Lebanese family, my uncles wanted to fight the disease and prolong the inevitable. They were willing to do anything to keep their mother alive. Even though they saw the pain she was in, the vision of how their strong and capable mother used to be never left their minds. Despite all the therapies and invasive procedures they desperately opted for in an attempt to grant her any 'extra days', my grandmother passed away a few weeks later.

Looking back, I regret the needless prolongation of my grandmother's suffering. I regret the last days of pain that were added by medical interventions because I believe she deserved to rest. Now I truly understand the importance of palliative care. As a society, we have yet to embrace the idea that the doctor's goal should not always be the prolongation of life. We need to contextualize each decision and consider the quality of the life, for fighting may not always be the best option. As physicians, we will inevitably face many limitations in curing diseases and extending lives. But when considering all your options, do not forget that letting your patient peacefully pass away is a valid option too.

MBA: MEDICAL-BUSINESS ASSIMILATION

By Aya Hamadeh
Med 2

Healthcare today demands that members of various levels within the healthcare industry – such as physicians, policy makers, researchers, and hospital CEOs – possess strong leadership and management skills in addition to their medical know-how. Medical graduates are increasingly interested in taking consulting jobs within the healthcare industry. Some are even willing to venture into entrepreneurship and startups aimed at creating innovative solutions for medical problems (1). Additionally, many Lebanese medical graduates are opening their own private clinics, choosing to become business owners as well as physicians. However, most students have not received any formal business education and are often not well-equipped for management and leadership positions (1). Despite the integration of more problem-based and team-based learning, students still lack the fundamental business and leadership skills and knowledge needed to create change within and help advance the industry (2).

In the United States, many medical schools offer a dual MD-MBA program while several others offer business specialty track programs alongside the core curriculum providing insight into the business aspect of medicine. Teaching medical students basic business concepts and skills such as management, team work, and data analytics, allows them to better understand how a hospital operates. Data analytics skills, for example, can be used to better manage finance and operations within the hospital thus improving workflow. Business courses also provide novel approaches to dealing with problems that do not have evidence-based conclusions or predetermined guidelines such as those that arise in preventive medicine and end-of-life decisions (3). Ultimately, the integration of business in medical education allows future physicians to build bridges with the healthcare community around them, facilitating communication between the administration, healthcare providers, and policymakers (4).

The current Impact Curriculum at AUB still lacks many of these fundamental business concepts. Integrating a business course alongside the currently taught Global Health, Research Design, Patients, Physicians and Society (PPS) and Evidence-Based Medicine courses could help students resolve some of the leadership and managerial challenges they will face in a hospital setting. The course could be a first step towards elevating management abilities that would support the clinical knowledge medical students have, preparing them to deliver higher quality care. Fostering skills such as communication, cooperation, decision-making, and operations management can be facilitated through business courses and will lead to better organization, increased productivity, and better integration within a hospital.



References:

1. Ercolano, P. (2017, March 31). Johns Hopkins experts propose business training requirement for med students. November 12, 2017, from <https://hub.jhu.edu/2017/03/31/med-school-should-require-business-management-classes/>
2. Pearl, R., & Fogel, A. (2017, August 07). New Physicians Will Need Business School Skills. Retrieved November 12, 2017, from <http://catalyst.nejm.org/new-physicians-need-business-school-skills/>
3. Pathipati, A. (2016, October 19). About Scope. Retrieved November 12, 2017, from <http://scopeblog.stanford.edu/2016/10/19/why-im-doing-an-mdmba/>
4. Pathipati, A. (2017, March 08). How to apply business to medicine. Retrieved November 12, 2017, from <http://www.kevinmd.com/blog/2017/03/apply-business-medicine.html>

لاجنُّ في زورق

سحر قوبر د.

حمل ما تبقى من ذكريات
وضعتها في صندوق من خشب
أحكَمَ عليها بابَ قلبه
أودع المفتاح تحت تراب الوطن
ورحل...

تاركاً وراءه أحلاماً
أخبرها لساحة الدار وللعريشة
حباً كتبه على جذع السنديانة العتيقة
أزهاراً عمرها مئة سنة
أمطرتها السماء بحبٍ شتاءً
وأمطرها هو من قطرات قلبه صيفاً
تاركاً مقعداً لجديته ولأبيها ولجدّها من قبلها
تاركاً عبق الياسمين وعبق الذكريات
تمنى لو يعبئه في زجاجة
ويأخذه معه إلى المنفى

أبقى على الشباك مفتوحاً
عَلَّه يحمل إليه ريح الأمل
أمل العودة
وعلى طرفِ ذاك الشباك
حطت عصفورة رحالها
وبنت عُشاً لأطفالها
رحل هو وجاء الغريب يسكن بيته
يحتل مملكته ويأكل رزقه

حمل الصندوق إلى الزورق
جمله ثقيل... كجمل ذكرياته
حمل أثقل ظهره
إلا أنه كان على المركب خفيفاً
فقد ترك قلبه خلفه
في أحضان من أحبه... في أحضان الوطن
ورحل...





BEHIND THE WHITE COAT

What is an inspirational book that you would recommend to medical students?

Dr. Nabil Mounla
Amongst Women
By John McGahern

Dr. Joseph Nassif
Kill or Cure
By Steve Parker



Dr. Ghassan Hamade
Thinking, Fast and Slow
By Daniel Kahneman

Dr. Deborah Mukherji
The Glass Palace
by Amitav Ghosh



Dr. Johnny Salameh
Awakenings
by Oliver Sacks

Dr. Anwar Nassar
The Other Side
by Kate Granger



Dr. Nesrine Rizk
Zorba the Greek
by Nikos Kazantzaki
Or
A Hundred Years of Solitude
by
Gabriel Garcia-Marquez

Dr. Thalia Arawi
The Plague (La Peste)
by Albert Camus



Drawing by
Sara Catherine Mourani