Dear SMS,

Thank you for taking the time to read the latest issue of H&P, entitled Generations: an homage not only to the evolution of Stanford but also to the zeitgeist of medicine itself. Core to the philosophies of these institutions – both conceptually and concretely – is the propagation of clinical and scientific knowledge to nascent leaders, visionaries, healers, teachers. Investing in this future entails preserving the principles upheld by predecessors while simultaneously integrating innovative and fluid transformations into the endeavor at hand. It is this spirit which we have highlighted herein – a generation defined not only by chronology, but by the ideas and leitmotifs upon which we expound and embrace.

H&P has recently undergone major structural changes – we would first like to welcome Diane Wu (SMS II) as our newest co-Editor-in-Chief. We also welcome Stanford’s medical school class of 2016, many of whom have joined our editorial board. Each brings their repertoire of talents and interests to the journal’s table, and together truly embody the flux of progress that we hope to achieve as a publication.

Continuity is another parameter inherent to the concept of generations, and here we introduce two columns intended to be reproduced longitudinally. Sarah Waliany (SMS I) hearkens back to the environs of 1970 at Stanford, comparing H&P to its predecessor (entitled The Organ). This piece is a unique “Snapshot in Time,” illustrating the nuances between our journal, didactic sessions, and the technology to which we have become accustomed today, and their analogous counterparts from 30 years prior. Sasi Madugula (SMS I) initiates H&P’s first satire column, providing a humorous parody of the controversial student feedback system.

A central tenet of knowledge transmission is internalizing the perspectives of our seniors, such that we can effectively translate it for those to follow. Michelle Linh-Nguyen (SMS II) explores a day in the life of Dr. Vivek Bhalla, an influential preclinical instructor in nephrology. Victoria Boggiano (SMS I), Trishna Narula (SMS I), and Sarah Waliany (SMS I) narrate their conversations with Drs. Charles Prober and Preetha Basaviah – two physicians who have saliently impacted the lives and education of medical students at Stanford. Victoria Boggiano’s dialogue with Dr. Abraham Verghese offers unprecedented insights into the author’s introspections and methodologies.

Some experiences, however, remain largely immutable in their ability to elicit emotion, despite the generations that they traverse – anatomy dissection as the paradigm. Larissa Miyachi (SMS I) and Sasi Madugula (SMS I) present lyrical poetic compositions inspired by this classic rite of medical passage. Jennifer Wang (SMS IV) chronicles a timeless anecdote from her interval in the hospital wards, and Casey Means (SMS IV) reflects upon the nuanced linguistic peculiarities innate to the physician’s journey.

Interdigitated within the following pages are photographic sequences taken by James Pan (SMS I) and other students, showcasing traditional events that have or will come to define the SMS community – global health expeditions and the SMS cup.

We are honored to present this archive of revered history, with all the conventions and revolutions that have hewn the philosophies underlying the spirit of Stanford medicine.

Sincerely,
AARTI SHARMA AND DIANE WU
The Medical Lexical Adventure
CASEY MEANS

First Anatomy Experience
SASI MADUGULA

Retina
LARISSA MIYACHI

Last Breath
JENNIFER WANG

The Tennis Partner: An Author’s Perspective
VICTORIA BOGGIANO

A Day in the Life: Dr. Vivek Bhalla
MICHELLE LINH-Nguyen

A Snapshot in Time: The Organ to H&P: The Stanford Medical School Journal
SARAH WALIANY

Satire: Feedback on Feedback
SASI MADUGULA

SMS Cup
JAMES PAN

SMS Around the World

Dr. Charles Prober
TRISHNA NARULA & VICTORIA BOGGIANO

Dr. Preetha Basaviah
SARAH WALIANY
IT IS ESTIMATED THAT ASPIRING DOCTORS LEARN 15,000 WORDS IN MEDICAL SCHOOL— the equivalent of a college graduate’s vocabulary. Simply, becoming a doctor involves learning a new language. As a life-long student who struggled through years of obligatory high-school Spanish classes, and still hasn’t progressed very far past “¿Donde está el baño?,” I can safely say that the language of medicine has been the most rewarding to learn. Many of the words that compose the medical lexicon are illustrative descriptors of bodily phenomena (lichenification!), some are compact verbs describing complex physiologic processes in one fell swoop of syllables (extravasate!), some are just vexing names of drugs (bevacizumab...). Regardless, many words of medicine are artful and lyrical, with potential utility beyond the walls of the clinic and in the realm of personal understanding and fulfillment.

By nature of being deployed in medical practice and thus necessitating efficient description of clinical details, individual medical words have become charged with nuanced and complex meaning, making them powerful and deliberate. Within the wards, “yellow skin” is no longer sufficient; rather, a patient’s complexion is icteric. Yellow
could describe an aged bruise. Yellow could refer to the shade of skin with pus churning underneath. Yellow could merely be a hand stained with curry. But icteric skin is the pelt worn by an individual with a serious gastrointestinal abnormality, likely liver disease with concomitantly elevated circulating bilirubin. The icteric patient needs liver function tests ordered immediately to determine the origin of their jaundice and to dictate the correct treatment; as for the “yellow” patient – who knows?

The language of medicine has evolved through uniquely dynamic means, sprouting from all corners of the globe without a germinal geocultural nidus. With new scientific discovery comes new need for words, and in the world of healthcare, innovation is never-ending. While some words such as “excoriate” (meaning to scratch ones skin harshly, to the point of bleeding) are derived from Latin (with ex meaning “out” and corium meaning “skin”), other medical terms such as “sonic hedgehog” (a critical protein involved in cell turnover) are borrowed from pop culture by young graduate students who embrace the opportunity of naming a newly discovered protein after their favorite 90’s SEGA video game. The language is a unique global and egalitarian web of thought, untethered to an overarching sociohistorical trajectory intrinsic to most languages.

The acquisition of this new language is more than just a necessary hurdle for the aspiring doctor – it is a literary candy box of new ways to speak of, and perhaps think about, the body. While my premedical vocabulary limited my description of a rash to “red and itchy,” I can now paint a much more specific corporeal experience: my bumps are diffuse pruritic erythematous excoriated papules. Bruises? No! Rather, violaceous ecchymoses. With all those descriptors, I cannot think about a rash, a bruise, or the nature of my skin, for that matter, the same way again. Rather than the processes of the body being mysterious and internal, descriptive medical words provide a way to talk about and understand the happenings of the body in an articulate, physiologic, and demystified way.

Linguistic theory posits that language shapes the way a person literally perceives their surroundings. For instance, in the Russian language there is an obligatory linguistic distinction between dark and light blue; in contrast, the general word “blue” in English is sufficient to describe any shade of blue. Psychological studies have found that Russians are able to visually discriminate different shades of blue more accurately than English speakers. These studies have led to the hypothesis that the language one speaks may directly influence one’s perceptive capabilities. In medical school, we are taught to think about the body through the lens of thousands of new words. One wonders, then, if these words lend the doctor a unique opportunity to quite literally see the body differently – to perceive the shades of blue, so to speak?

Within the acquired lexicon of the medical profession there is utility and art. Somewhere in the beauty of the language, there is an open door to increased fulfillment. With words come perspective, power, and self-discovery. With words we have the privilege to articulate and share that which resides within. In a student’s or physician’s long days of school and clinical practice, perhaps an increased appreciation for the art of the medical lexicon will provide that little extra burst of inspiration that keeps the joy of medical practice alive.

“Many of the words of medicine are artful, lyrical words, with potential utility beyond the walls of the clinic.”
First day in the lab, good fun to be had, strap on the scrubs and rubber
A moment of grief, roll back the blue sheath, stand and look and shudder
The body there lies, awe filling our eyes, a daughter, sister, mother
Formaldehyde fresh, simple pale flesh, then someone murmurs “let’s cut ‘er”

Make the first cut (please don’t hit the gut), unsteady, unsure, and slow
Some make a fuss (“that’s inside of us!”), excited, be sure, but hollow
For that first day, we teeter away, and as to home we go
We think we dream, of the deathly sheen, flesh as white as snow.

Fourth week in the lab, facts to be had, fun to be had too
Impatient to start, let’s look at a chart: “this is what we do”
The lungs there lie, greed in our eyes, the veins stained blue
“A cut to the hilum, the lobes--divide ’em. Let’s jump to it crew!”

Must know the facts, the ducts and the tracts, no room for fallacy
Two lungs hit the table, thrown and then labeled, we crowd around to see
“They’re faulty specimens!,” bless his acumen, let’s look at another body
That night we dream of vessels and spleens, our knowledge of valves ain’t shoddy

Dreaming of hearts, we wake with a start. Forgot if it’s a he or a she.
SACRED

A sea of blue
Blue bags
Blue scrubs
We stand
Heads bowed
A moment of
Silence

A wordless prayer
That I may be
As generous as
You

And in this moment
This windowless
Room with its
Blue bags and
Blue scrubs
Becomes a
Cathedral

BLUE

This is the color of hope
The color of the sky
Where dreams take flight
In the light
Reflected on the wing
Of a jay
The hue of a feather
Touched by the breeze
Flashing sky
The hue
The cry

This is the color of sorrow
The color of the mist
Hovering
In the deep forest
Of shadows cast
Upon a frozen land
Listening
Waiting
For the song
Of the solitary bird

Hope and sorrow
Alike
Paradoxical
One born of the other
For without tears
Without pain
What is hope?

It is the promise
That the broken wing
Will fly again
That the lost feather
Will find a home
Woven into
A springtime nest
That the mist will break
And become clouds
Dancing across
A bright
Azure
Sky
FROM WHAT I OVERHEARD, SHE WAS LIKELY GOING TO DIE THAT AFTERNOON.

It didn’t hit me that hard when ‘she’ was just a name (let’s call her Esther) with a diagnosis (‘sepsis’ is never a good thing) on the board in the resident’s lounge.

But when I walked into the step-down unit and saw the intern and resident intensely conversing with the nurse, their faces lined with concern, I started to wonder if this was a good idea. I peeked into the patient’s room. It was dark. I could hear the beeping of machinery and the rhythmic bellowing of a ventilator, and see the billowing movements of the heating blanket that all but buried the patient. I couldn’t get a glimpse of her. Her husband stood in the shadows, immobile as a pillar. His hands were clasped in front of him, as if he were holding onto the little bit of hope and faith that brought him this far.

I gingerly made my way inside with uncertainty. Did I belong here? Was I intruding on some sacred space between the patient and her husband, into what might be their final moments together? He regarded me with a nod. I didn’t know what to say. So I allowed him to talk. He told me that it had been a long struggle with Esther: three years of chemotherapy, of pain, of suffering. He told me that he did not want her to suffer any more. Even in the dark, I could see his eyes behind his thick-rimmed glasses,
bloodshot and glistening with emotion. All I could do was nod and place my hand on his shoulder.

We both watched Esther gasp for life. Despite the mask blowing oxygen-enriched air into her nose and mouth, she was curled up in a ball on her side and working very hard for each breath. Forty-seven per minute. She looked exhausted already, though she had only arrived in the hospital that same night. Her eyes remained closed, and she barely looked up when spoken to. Leave me be, her body seemed to say. Her expression said, Please save me.

When the ventilator failed and the rapid response team was called, my mind and body froze. The non-rebreather mask was not going to provide enough oxygen to her while the new ventilator machine was being hooked up. Esther became very anxious.

Help me, I can’t breathe, help me.

Her oxygen saturation dropped into the 70s. The intern held her hand and looked her intently in the eye. Take slow, deep breaths. Slow, deep breaths. I needed to remind myself to do the same.

After the chaos subsided, I left the room with a queasy feeling in my stomach.

No, I’m not scared. Everything is okay now. She is breathing fine now. She hasn’t passed yet.

My balance was a little askew as I walked up the stairs to find a quiet room to finish my note for the morning. My eyes were a little watery, my breaths a little shallow.

No, you can’t cry now. You have to present this patient at rounds. Get it out of your system, don’t think about it. Focus on finishing your note.

When it came time to present, I tried to stay objective. Distant. I buried the image of Esther struggling for air as I systematically recited her latest vital signs. “Temperature of 35.9. Respiratory rates in the 30s to 40s on 50% FiO2. (The intern interrupted: it’s now 80% FiO2.) The patient’s general appearance—Her breathing was...labored...”

It was all I could say before I was overtaken by my thoughts of the woman so hungry for air, drowning under the trappings of modern-day life support, her eyes filled with fear and surrender. My breathing, too, became ragged.

What was the point of all this? Did the subtleties of her chest exam really matter when any of those breaths I auscultated could have been her last?

Esther slowly turned around during the afternoon, her oxygen requirements attenuating but still considerable. I was relieved that her name was still on the list when I arrived for sign-out the next morning, and the next, and the next. The initial trauma of that first morning continued to weigh on me each time I stopped by her room during pre-rounds, but it was comforting to see her sitting up in bed watching the early morning news, to hear her responses to my simple, hesitant questions get longer and louder as her pneumonia—the reason for her initial decompensation—slowly cleared.

She didn’t remember who I was when I went to visit her the second morning. I told her my name. “Oh, that’s my oldest daughter’s name, too.” We smiled at each other. I met her two daughters at the family meeting the next afternoon. They were not that much older than me. Like their father, they were quite aware of how ill she was, how much she had suffered over these past few years. Her primary oncologist was present and informed the family that continuing chemotherapy at this stage of her illness would likely cause her more harm than good, that having
After a brief silence, I prompted that there must be a lot going through her mind lately. She nodded, and then turned her eyes towards the TV screen, her gaze distant.

“I guess I’m okay with it,” she started, a little too matter-of-factly. “We all have to die. I have faith in God, and if God says it is my time, then I guess I am okay with it.”

She flashed me a weak smile before returning her attention to the afternoon news.

On a cloudy Sunday morning, Esther was discharged in stable condition on hospice. Her daughters had arranged for a wheelchair, a hospital bed, and other medical equipment to be delivered to their home that afternoon, so that their mother could sleep sitting upright with oxygen support if she felt short of breath. As she left the hospital, I watched her slowly shuffle down the hallway with a walker, her daughters wheeling a tank of supplemental oxygen closely by her side. She was still weak and slightly wobbly on her feet but had insisted that she could make it to the car without a wheelchair. She wasn’t going to give in that easily. No, not until her very last breath.

Several days later, I went to visit Esther in her room. She was sitting in a chair eating a plate of mashed potatoes and green beans, a nasal cannula hanging lopsidedly across her face. She smiled and put her fork down as I entered her room, sunlight streaming in from the window. I asked her the usual questions about how she was feeling and how her breathing was, and we made some small talk about the vase of red lilies her daughters had brought her. She was now able to speak in short sentences.

The family, composed but tearful, seemed to understand where the conversation was headed.

Esther, however, appeared confused. “What do you mean, no more chemo? Isn’t there something else I can try?”

The oncologist and her daughters explained to her the big picture once again, focusing on the importance of making sure she was comfortable and able to enjoy the time she had left in this world. But it was obvious from the stony look on her face that “no more chemo” was all she had heard during that hour.

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THE TENNIS PARTNER:  
AN AUTHOR’S PERSPECTIVE  
VICTORIA BOGGIANO

Dr. Abraham Verghese’s *The Tennis Partner* is a powerful narrative about friendship, addiction, medicine, tennis, love and loss, the AIDS epidemic in the 1990s, and much more. The autobiographical memoir recounts Dr. Verghese’s friendship with a kind-hearted but troubled medical trainee named David. When they met, David was finishing his fourth year of medical school and Dr. Verghese had just begun his new job as Professor of Medicine and Chief of the Division of Infectious Diseases at the Texas Tech Health Sciences Center in El Paso, Texas. As it turned out, the two men shared a passion for tennis (with David a former professional tennis player from Australia, and Dr. Verghese a tennis fanatic since his childhood days in Ethiopia) and both were in need of companionship. Before they knew it, they began spending several evenings a week on the tennis courts, talking about their past, their present, and their hopes for the future – forging a truly once-in-a-lifetime type of bond. Yet David also harbored a dark secret that Dr. Verghese did not discover until several months into their tennis foray: a drug addiction so powerful that it finally overcame David and had devastating ramifications for everyone around him. The memoir is a sobering reflection on the power of addiction, and it is a must-read for all aspiring physicians. It shows us the dangers of allowing the loneliness of medicine to supersede all else, and the importance of maintaining connections with those who can help in the greatest times of need.

I had the opportunity to sit down with Dr. Verghese this autumn to ask him about the memoir and about how the lessons from the book can instruct future medical professionals.

**Victoria Boggiano:** What was your motivation for writing *The Tennis Partner*?

**Dr. Abraham Verghese:** I think the motivation was having lived through an extraordinary story, experiencing the friendship and then the loss of this young man. But I think it was also because it struck me that gay men and [heterosexual] women write so eloquently and beautifully about their friendships, but heterosexual men are notoriously reticent to talk about their deep friendships. And yet, I think these friendships are fundamental to our lives. They’re important to us. And I wanted to give voice to that. I think heterosexual men often couch them in sporting metaphors like “My tennis partner” or “My golfing buddy,” so I think that’s where it came from. It was also an eye-opening story for me. I didn’t know much about addiction. I thought I did, but clearly I didn’t.

**VB:** Have you ever had another friend like David – either before or after you met him?

**AV:** Yes, I think several, before and after, but I think most of those were not in medicine. There was something very interesting about seeing addiction highlighted in the medical profession – a paradox, in a way. Here we are supposed to be ministering to others, and
yet a doctor can, while in the throes of an addiction, believe he or she can still care for others... I think that was the real education. I knew medically about addiction but I didn’t viscerally understand some of the nuances to it and I did not really understand recovery. Understanding the meaning of what it is to be addicted – the powerlessness, the helplessness, the importance of AA groups and NA groups – all of that was because of David.

VB: As you were writing the book, who were you envisioning as the reading audience?

AV: I don’t think I had a vision like that, but I was writing under contract with a major publisher. So I think that I’m picturing an interested reader; someone like you. Someone who is a selective reader, and who doesn’t have much time on their hands. My job as a writer is to bring them in as quickly as I can and not bore them, not let them down, and keep them turning the page.

VB: You talk about ‘ritual’ frequently in the book - the ritual of internal medicine, the ritual of tennis, the ritual of your relationship with David. What is it that made you gravitate to this idea of ritual – if it was in fact a conscious choice – and what are the rituals in your life now?

AV: Honestly, I don’t think one initiates books with an express intention of, “Well, I’m going to have a theme of ritual.” The themes emerge after the fact. But I’m surprised to hear you say this because I’m very interested in ritual now, but a different sort of ritual – the ritual of the bedside exam.¹

Now that you mention it, you’re right: what I love about tennis is the ritual and it was lovely to describe that. And what I love about medicine, especially the bedside exam, is that ritual. But more recently, after writing the book, it’s become apparent to me that when you examine a patient there’s an important ritual that’s taking place. And I think I only understood this after coming to Stanford and interacting with people in anthropology. Because you can think of the exam as a history and physical exam. But it’s actually more than that. One individual who you’ve probably never met, [...] who sometimes is twice or thrice your age is telling you things that they wouldn’t tell their rabbi or their preacher, and then incredibly they are then undressing and allowing touch, which in any other context would be assault. It’s happening in a room where the furni-

ture doesn’t resemble furniture in your rooms or mine, you’re wearing a ceremonial outfit, [and] they’re wearing one too, so it really has all the trappings of ritual. My colleagues in anthropology point out that rituals are all about transformation. We engage in rituals to signal the crossing of a threshold – for example, bar mitzvahs and baptisms and weddings and funerals.

So you might ask: what’s the transformation in this ritual? I think the transformation is the sealing of the doctor-patient relationship. If you just sit behind a desk and order tests, you’re not going to form the same bond as when you do a skilled exam – and it must be done with skill. It’s not enough to just do the steps of the exam. You have to do it with some skill. William Osler said many years ago that our patients will judge us not by the certificates on our wall but by the manner and skill with which we carry out the least maneuver. So I think ritual has interested me – perhaps rituals interest all of us and we just don’t know it. We’re full of rituals. I think that perhaps it’s by the rituals we choose and the ones we observe that we find meaning in our existence. Because they’re all little transformations. Sometimes they’re things that we need to repeat every day. Prayer for example. Or whatever the ritual is that you seek. Coffee.

I think as a writer, too, it’s always nice to understand the mechanics of something. There’s a reason why there are so many police and hospital shows on TV because they’re all procedurals. The background is a very dense, stereotyped, and ritualized process: Cops, booking stations, holding cells, interview cells, etc. The hospitals have the same sort of rituals: operating room, ER, corridors, cafeteria. So I think in the same way, anything that has a dense ritual, if you convey the ritual well, then you can make it appear interesting to the reader. I’m not that interested in golf. I don’t play golf– I’ve never played golf. But I love reading John Updike on golf because there’s something delightful about hearing the intricacies of the game from a writer who’s thought about it carefully. So I was hoping to do the same thing for tennis.

VB: How did your friendship with David impact your time in El Paso?

AV: I think I remember El Paso for many different things. One of them is very much the friendship with David. The other was that although I had had a considerable AIDS experience by then – I had been in Boston and Iowa and Tennessee – the longest spell of my AIDS experience was actually in El Paso. And I met my now ex-wife in El Paso and had my last child there. It has a very poignant connection for me, many things good and bad. David is... this many years down the road, David is all good. I feel sad that he’s not here and I feel sad that he didn’t survive, but I feel very proud of my friendship with him. I feel proud that I was able to memorialize it like I did. I’ve never gone back and read The Tennis Partner. I think I’m waiting for my ripe old age or something. Mostly because I think immediately when I start reading there’s an instinct to want to correct. I’ve also never read My Own Country again. Cutting For Stone I’ve wanted to read but have not... Not yet.
VB: How did your friendship with David impact the way you practice and teach medicine today?

AV: I think it’s taught me a lot of humility. It awoke me to the sense that we’re all flawed. His ‘flaw’ manifested itself in this propensity towards addiction. I also think that it was very humbling for me to have been in practice that many years and not understand addiction. I was not the veteran I am now, I suppose, but I’d been out of medical school and out of training for about seven years by then. So I was seven years into practicing medicine and still hadn’t fundamentally understood that addiction was truly a disease. Some little prejudicial part of me kept seeing it at some level as a personal weakness, even though I knew better. But something about seeing it in David and through him seeing it in many other physicians who I met at the Talbot-Marsh clinic\(^2\) made me see that, yes, bad choices or moral weakness might have started the whole thing. But once it was entrenched, it had nothing to do with choice. It was a horrible disease. Every one of these people wanted to break free but couldn’t. Which is why when they were caught, they had two overwhelming reactions: one was tremendous shame to the point where they wanted to kill themselves, and that is why immediate hospitalization is warranted. But the second reaction was great relief. It’s a paradox: shame, but also relief because they knew they were – to paraphrase the Alcoholics Anonymous epithet – “powerless in the face of their addiction,” and they just had to hit bottom. Which in [a] physician’s case is always a confrontation with the organized part of medicine. We’re blessed in that way, I suppose, because you could be in any other profession (except for being a pilot) and get drunk and relapse and get better and relapse and there’s no real consequence other than the personal ones. But in medicine, the consequences are all professional—you are not allowed to practice. Which is a good thing. As a result, the recidivism rate is so low among physicians since your livelihood is at stake.

VB: That was going to be my next question, because the

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\(^2\) A drug treatment facility for physicians in Atlanta, GA, where David went for treatment.
most shocking part of the book for me was when you found out that David had been planning his first relapse since your friendship began for months, when it seemed to me that his situation in El Paso was perfectly structured so that he would be safe from such a relapse. So how do you create a world that he can re-enter, or that any physician dealing with addiction can re-enter, that they will be least tempted to relapse?

**AV:** I think his relapsing was a good sign that David had not finished his treatment, had not completed therapy. It’s always going to be one day at a time. There’s always going to be temptation, but I think some part of him was still in denial, thinking he could still ‘play’ the system. Or some part of him was also still deeply troubled and he needed the addiction to complete himself. If you’d gone through the therapy whole-heartedly then you know you can’t trust yourself, that the ‘stinking thinking’ takes over, and as soon as you see signs of it you’re supposed to call your sponsor. And no one knew that better and no one knew more about the disease than David. I don’t know if you’ve ever known people who have been addicted, ever been close to them. Chances are that you carry a lot of guilt because you are co-opted by your affection for them; you become co-dependent in a funny way. It took some years and writing the book to recognize that I wasn’t responsible for what happened to David. Ultimately, no one knew more about the disease than David, and David was responsible for David’s addiction.

**VB:** Do you think that Emily had the same sort of ability to remove guilt and blame from herself?

**AV:** I think it took her a while, too. But Emily had an even more powerful addiction in the form of an eating disorder. I think that’s the hardest addiction to overcome because you have to live on this substance over which you are powerless. So I think as much as she felt sorrow and tried her best to help David – as we all did – I think ultimately she feels as I do: that he succumbed to his disease. The disease is powerful, but there’s only so much those of outside of it can do. The analogy might be the disease of diabetes: You can prescribe the insulin, the diet, the footwear, and exercise, but it requires the patient to take responsibility, to actually do what is required. It’s probably one of the most frustrating things for a medical student – the moment of disillusionment comes when you recognize that not everybody is there just happily waiting for you to tell them what’s wrong and here’s the treatment. Many of them are actually hell-bent on destruction and you have to love them despite that.

There’s a line from Paracelsus [...] which I always think about in the context of David. It’s asking God to give us certain properties. It asks especially for the power to “…love the sick, each and all of them, more than if my own body were at stake.”

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**The Oath of Paracelsus**

*This is my Vow:*

To perfect my medical art and never to swerve from it so long as God grants me my office, and to oppose all false medicines and teachings.

Then to love the sick, each and all of them, more than if my own body were at stake.

Not to judge superficially, but by symptoms, nor to administer any medicine without understanding, nor to collect any money without earning it.

Not to trust any apothecary, nor to do any violence to any child.

Not to guess, but to know.
“I think the transformation is the sealing of the doctor-patient relationship. If you just sit behind a desk and order tests, you’re not going to form the same bond as when you do a skilled exam—and do it with skill.”

VB: At the end of the book, you talk about how medicine fosters loneliness and I had the impression that perhaps loneliness is one of the factors that contributed to David’s downfall in the end. So how do we as future medical professionals prevent this loneliness from enveloping us?

AV: All of you come to medicine for personal reasons, typically something that you encountered in your life—a family member’s illness, something deep that brings you to medicine, this calling to serve. You come for all the right reasons. Then a strange thing happens when you go from your preclinical to your clinical years, or as I call it your “pre-cynical” to your “cynical” years. You arrive on the wards and you’re going to see some shocking things very quickly, especially in a county hospital. The kind of carnage you will see on a regular basis is shocking, and you will find (this was especially true in my era, though I think it’s less true now) that no one has the time to stop and talk about how shocking it is. It’s all quickly reduced to the biological. Not that we don’t feel, but especially when it’s an acute emergency there isn’t really time to think about what it all means. It should all be about Airway, Breathing, Circulation—the ABCs. But in the machismo of my era people actually used to say, “Hey, do you remember the great case that came in last night with the ax buried in his head?,” as though the guy didn’t have a widow and five children. I think that represented a kind of defense. So as you deal with so many people, with so many emotionally wrenching conditions, one way to survive is to disconnect the emotional content of what you’re seeing from the physical and disease content. The great danger, of course, is that you will do this kind of disconnection with yourself. By that I mean, that when we get stressed, instead of figuring out what is happening to us emotionally, there is a danger that physicians will just focus on a symptom and self medicate with alcohol or something else. And that seemed to have been the key to addiction in many physician stories I heard. If AA and NA work it is because they tackle head on the secrecy and loneliness that is typical of an addict. They force you to give up your secrets and repopulate your world. Well, I think there is a lot of loneliness and lots of secretiveness in medicine. It feels like a solitary quest to get to med school, to get through, to graduate. But your friendships, your family, your web of connections are crucial to your well being, to your good health. So my advice is that you must treasure the relationships you form both here and outside of medicine. And when you see a classmate or a colleague start to withdraw, reach out. You can make a difference. You might save a life, a career. Being a physician begins with taking care of ourselves, and our colleagues.
A DAY IN THE LIFE: DR. VIVEK BHALLA

MICHELLE LINH-NGUYEN

I HAVE LOVED BEING A MEDICAL STUDENT AT STANFORD. But that doesn’t mean that I consider the pre-clinical curriculum here flawless. As in any other setting, there are moments when I sit in the last row of LK120, hands over eyes, feeling disengaged, wishing that I understood the logic in the same way as our instructor decided to present material. I do not want to take for granted that we are surrounded by brilliant and persevering minds at this institution, but I also want to acknowledge the individuals I’ve come to admire most: those who have taken the time to synthesize their expertise to the degree that allows them to step back and present it in a way that can engage even the most ignorant of minds.

This autumn during renal block I quickly gathered that Dr. Vivek Bhalla is one of these individuals. Medical students are most familiar with Dr. Bhalla’s role as the course director of the pre-clinical renal block. Writing a ‘Day in the Life’ piece seemed like an opportunity way to shed light on other facets of his every day life as an Assistant Professor of Nephrology at the School of Medicine, a physician-scientist, and a family man.

During this past August and September, I found myself uncharacteristically excited to attend morning lecture, a rare phenomenon for a night owl. I was not an isolated data point in my enthusiasm for Dr. Bhalla’s lectures; I’ve presented three supplementary pieces of evidence below:

(1) Dr. Bhalla was the 2012 recipient of the Henry J. Kaiser Family Foundation Award for Excellence in Preclinical Teaching.

(2) On the first day of renal block, my classmate Elena and I—consistently noncommittal inhabitants of the lecture hall’s back row—turned to each other with goofy smiles, hands to our hearts,
and swooned over Dr. Bhalla’s simple statement: “I am going to teach you three things today. I know this can seem overwhelming, but we’re going to take this one step at a time.”

(3) I lost count of the number of times I heard something along these lines after the renal exam: “Guys, I’m thinking maybe I want to be a nephrologist now... I LOVED renal. But maybe it was just because of Bhalla...”

And that was truly considered an important confounder to address: Did we want to be nephrologists? Or were Dr. Bhalla’s course organization skills and teaching style so persuasive as to just make us think so? Did it matter?

As I recounted these conversations to Dr. Bhalla, he smiled, “That’s good to hear; I’d like to contribute to that movement.”

Nephrology is an oft-overlooked field, especially at Stanford; nephrologists interested in basic science research are especially rare. I came to recognize that Dr. Bhalla is a resolute advocate for this career path, one he feels requires more curious minds.

When I asked him why he chose nephrology, his answer was straightforward: “That’s an easy one, actually.” Dr. Bhalla studied Electrical Engineering during college and consequently assumed he would go into a field such as electrophysiology/cardiology or neurology. He knew nothing about nephrology before going through renal block in medical school. “The block that I teach now... that same block is what inspired me. After that block, I knew. People rarely know that early, but I did.”

It is always satisfying as a writer to observe a plot line come full circle: years later, Vivek Bhalla is playing the same inspirational role a nephrology professor once played for him at the University of California, San Diego, School of Medicine. In the course of writing this piece, I spent time with Dr. Bhalla on two separate occasions: one afternoon in his research office and one morning in Nephrology Clinic. The following is a compilation of my experiences during these occasions.

RESEARCH SCIENTIST, MENTOR & FATHER

The Wednesday I visited Dr. Bhalla’s academic home in CCSR, Dr. Bhalla was neatly dressed in a suit and tie having returned from clinic earlier in the day. He quickly dismissed my apology for being in my exercise clothes: “Oh, don’t worry. I’m usually in jeans and a sweatshirt anyway.”

His office was bright, with white walls, a wall-to-ceiling window, tan couch, family photos, and colorful children’s artwork neatly lining the walls. The piece that caught my eye was a red flower made of tissue paper and pipe cleaners taped securely to the wall above the couch. At first glance, I was convinced it was a creative rendering of a kidney. “Yeah, my daughter made that. You really think it looks like a kidney?!”

A whiteboard hung next to the door, covered in research notes likely only comprehensible to himself. It reminded me of my childhood spent in my father’s research office drawing cartoon faces on a board that was more accustomed to displaying more sophisticated content.

He pointed out a picture of his daughter and son among the many displayed in a row on the top shelf of his desk. His son is smiling at the camera
casually holding a stuffed toy; his daughter is turned toward her older brother, ignoring the camera and clearly poised to snatch his stuffed toy. “She’s definitely a stealth klepto... she’s older than that now, but that’s her personality for sure.”

Dr. Bhalla spends the majority of his time here in his CCSR office. Nowadays, he rarely runs experiments himself, instead spending the majority of his time writing grant proposals, mentoring laboratory members, designing experiments, and weaving together scientific narratives.

He drops into his lab across the hall a few times a day, where molecular and transgenic experiments focus on elucidating the pathogenesis of diabetic nephropathy and salt-sensitive hypertension—diseases deserving increased attention as the prevalence of diabetes and hypertension continue to rise. Soon, he hopes to interface these basic science approaches with a project focused on serum biomarkers for diabetic nephropathy in partnership with the Palo Alto Medical Foundation (PAMF).

Despite the geographical proximity, partnerships between Stanford and PAMF seem few and far between, so I was pleasantly surprised to hear of Dr. Bhalla’s partnership with PAMF, an institution that sees more diabetic nephropathy in the primary care setting than tertiary care centers such as Stanford.

“It’s funny you say that,” he said after a pause, “because when I started the partnership I received a lot of, ‘How did you do that?’ There’s been a schism for some reason... and... I just called them.” This straightforward approach to challenges seemed a natural extension of his straightforward approach to teaching.

The Bhalla Lab fosters two post-doctoral candidates, one nephrology fellow, one research technician, and one undergraduate. Serving as a mentor for each member of this diverse group has its unique challenges.

“For the undergrad, who has limited time, how do you give them a challenging but also feasible project?”

And for the post-docs: “I help them navigate experiments and weave together stories.”

Guiding the nephrology fellow holds totally different implications. “This is a person who has gone through years of clinical training, and they are basically at the top of their game when they come to you to learn basic science methods... It’s hard to shift gears.”

“As a physician, you get a lot of short-term satisfaction; you come home from clinical work, and you can feel like you did something. Suddenly, you’re...
CLINICIAN, CLINICAL PROFESSOR, FAMILY MAN & TIME MANAGER

It was 9:15 AM as I bustled along next to Dr. Bhalla, short legs keeping up with long legs, as he strode to the nephrology clinic on the first floor of the Boswell Building. Between running a lab and giving medical student lectures, Dr. Bhalla holds his clinic every Wednesday morning from 9AM to 12PM. We arrived in a narrow room with calm air and computers lining the perimeter. He greeted a fellow attending physician, and they both laughed as I explained why I was there. “You know, if you really want to understand a day in our lives, catch us at 7-8 AM. THAT is the hardest time.”

Dr. Bhalla’s 7-8AM is occupied by the rush of he and his wife getting his three children—a 6-year-old, a 4-year-old and a 6-month-old—and themselves ready for the day. Arriving at work is often a welcome step down in energy level.

A different rush comes after work hours. “Both my wife and I are physicians, so there is this limited time that we can spend with our children. We have to balance having fun with the kids with getting them ready for bed. 5-8PM used to be when you relax, get a beer, hang out with friends, and now I have to be on top of my game!” Dr. Bhalla reflected, sitting on a rolling chair, legs outstretched in front of him. An avid Red Sox fan (a Red Sox pin is pinned proudly on his white coat), Dr. Bhalla plays baseball with his children several times a week. The 5-8 PM period is now set aside for these types of bonding activities.

That day Dr. Bhalla had five patients on his clinic
queue. He runs what he referred to as a “boutique clinic,” seeing mostly patients with conditions relevant to his research expertise.

“I don’t often have a lot of residents working with me because I have a smaller panel than others.” But that day we were an atypical team of four: Dr. Bhalla, an internal medicine intern, a third-year internal medicine resident, and me. As I watched him interact with the residents, I saw once again how his casual and straightforward air allowed others to feel at ease in his presence.

I also came to appreciate the subtle but consistent ways he showed his respect to patients. By 9:30 AM, the first patient had not shown, and Dr. Bhalla used the extra time to assign patients to the residents and finish up paperwork, such that by 9:35, as the first patient arrived late, everyone knew what to do and was ready to start. Dr. Bhalla rushed out quickly to make sure that his first patient—a young man with nephropathy secondary to Type I diabetes mellitus—was comfortable with being seen by a resident first.

In an academic medical center it is easy to take student-doctoring for granted. I was impressed with the personal responsibility Dr. Bhalla demonstrated towards each of his patients’ experiences. He made a point to ask permission of every patient before a trainee saw him/her first. “My patients aren’t used to being seen by students,” he explained.

At 10:00 AM I accompanied Dr. Bhalla to see this first patient, a man in his 30’s with cheeks dusted with dark stubble, sitting on the patient bench, slightly hunched, friendly but tempered. After introducing me, Dr. Bhalla leaned against the wall, facing his patient at an eye-to-eye level. This would be a common theme that day: besides introductions, the first step Dr. Bhalla would take when entering a room was to position himself eye-to-eye with the patient, whether it be sitting down a chair or leaning against a wall. It was clear that Dr. Bhalla had—whether unconsciously or consciously—adjusted his clinical style to account for his taller-than-average height to maximize patient ease.

As Dr. Bhalla finished going over next steps with his patient, he proceeded to the physical exam. As expected, he was efficient, asking specific questions as he performed a quick, problem-focused physical.

Working alongside residents that day, Dr. Bhalla spent an average of 15 minutes with each patient. On first instinct this smells of the suboptimal doctor-patient interaction we all as medical students have become inculcated against. Aren’t the patients frustrated that they receive so little time to talk with Dr. Bhalla? I cannot know for sure, but I observed nothing of the sort. In fact, most patients seemed surprised that Dr. Bhalla was asking their permission for student-doctor involvement and satisfied as they walked down the hall after completing their appointments.

It seems to me that Dr. Bhalla respects his patients in a manner that has become endangered in modern medicine: by providing prompt care and striving to make the time patients spend in clinic more efficient. Three out of five patients showed up late that day; none of them waited more than five minutes for care.

To be clear, the visits were fast, but they never felt rushed.

At 10:30 AM Dr. Bhalla prepared me for our next patient: a man in his 60’s with diabetic nephropathy who was accompanied by his wife, a source of invaluable social support. “He has a steady GFR,” Dr. Bhalla
explained, “It’s kinda nice. But he has a lot of cardiac risk factors... It’s more likely that he’ll succumb to those before getting to dialysis.”

By 10:45 AM Dr. Bhalla was sitting on a desk chair in Clinic Room 8 congratulating the couple for the progress the patient had made in cutting down on smoking. The doctor’s concern, now, was his patient’s hypertension. If left uncontrolled, it would increase risk of stroke and accelerate his decline in renal function.

Dr. Bhalla quickly ascertained that the patient had been drinking more than five cups of coffee everyday for a countless number of years. Cutting down on caffeine was “a good place to start,” he gently concluded, while maintaining emphasis on further reduction in cigarette smoking. The ease by which Dr. Bhalla performed this motivational interview intimated to the longitudinal nature of his relationship with this couple and the many prior visits spent discussing similar issues.

“Questions?” Dr. Bhalla asked, and we all sat in comfortable silence.

“We can’t yet cure many folks with chronic kidney disease, but we can slow progression. So an appointment like this [where the patient has a steady GFR] is a victory,” Dr. Bhalla stated as we walked back towards the physician workroom.

Back in the physician workroom, Dr. Bhalla illustrated a curve representing the decline of kidney function in diabetic nephropathy. Though the patient we had just seen was doing well, it was inevitable that his kidney function would still drop at rate of about 1% per year.

“All we can do is decrease the slope.”

At 12 PM, the two residents headed to a lunch conference, and I headed to class. As Dr. Bhalla prepared to head out with us, a medical assistant called him back. His last patient had just arrived late. He turned back with no hint of irritation and waved goodbye to me.

“It’s hard to want to be really good at everything,” Dr. Bhalla mused during our follow-up conversation in his CCSR office. “Everyone wants to be the Triple Threat—good at teaching, clinical practice and research, but you run the large risk of being the Jack of All Trades, Master of None. There are market forces that push you to choose between being a good clinician or a good scientist. It’s important to toe that line well.”

It may be exceedingly difficult to be a Triple Threat, but Dr. Vivek Bhalla is making a solid run for it.
ON A TYPICAL AFTERNOON OR EVENING IN THE MIDDLE OF AN ACADEMIC QUARTER, Lane Medical Library is packed with medical students engrossed in lecture notes, working on developmental biology problem sets or preparing for an OB/GYN shelf exam. Rarely do these students take the time to explore Lane, but if they did, they might stumble upon the Stanford Medical History Center in the library’s basement.

Currently undergoing some construction, the Stanford Medical History Center has a deceptively plain appearance that could prompt students to bypass its presence – and this would be an unfortunate oversight. The medical history center offers students a cherished glimpse into Stanford’s past. Cached within the medical history center’s collection of books, papers, and photographs are numerous issues of “The Organ,” the predecessor of H&P and published by Stanford medical students from 1972 to 1995.

All photos courtesy of Sarah Waliany and the Stanford Medical History Center.
I recently had the opportunity to explore the history center’s archived issues of “The Organ” with the help of Lane Medical Library’s historical curator, Dr. Drew Bourn. The journal has followed an interesting trajectory. It was initiated in the 1970s as an SMSA-run weekly newsletter comprising announcements regarding classes and student organization activities. A hallmark feature of the publication was a 2-3 paragraph description about a chosen organ of the week (from which the journal derived its name). Later, in the 1980s and 1990s, “The Organ” evolved into a bona fide journal, with student-written articles focusing on anatomical and physiological aspects of the human body. In this issue from January 14, 1975, the journal provided an educational piece about anatomy and the importance of hygiene in the medical field.
ing on Stanford-related events and experiences.

As I began to delve into the content of “The Organ,” I anticipated reading about the commonly perceived changes in the world of medical school, such as the increased prevalence of women in the medical field and a greater appreciation for humanism in medicine. Although the issues do occasionally touch on these themes, the sentiments evoked in the articles within “The Organ” resonate with the lives of medical students even today. From angst over histology in the pre-clinical years to a profound sense of humility during clerkships, it is evident that many experiences and emotions associated with medical school are timeless. The articles in “The Organ” range from satirical editorials to captivating commentaries chronicling how Cooper Medical College became the Stanford School of Medicine. The articles foster an appreciation of the advancements culminating in the school that we cherish today. Many of the articles in the journal also provide entertaining ad-
vice from medical students about how to survive (and even thrive) during pre-clerkship and clerkship years.

Henceforward, *H&P* will include a column entitled “Snapshot in Time,” which delves into the lives of medical student predecessors through articles from “The Organ.” These articles allow us to pause and compare the experience of being a medical student today with what that same journey was like decades ago. In this issue, we are excited to present an entertaining, satirical article from the January 14, 1975 issue of “The Organ” that advises first years on how to muddle through the anatomy dissection, with a special emphasis on hygiene. The “hints and observations” provided by co-editors Jim Lee and Bill Rollow reveal the time-less nature of taking an anatomy course: the fear of cutting nerves in the brachial plexus, the awkwardness of dissecting the inguinal canal. Whether you belong to the groups described as “slashers” or “gawkers,” I am sure that you can appreciate this entertaining article. The drawings flanking this section have also been reproduced from “The Organ.

In a way, the “Please Do Not Open” sign between the Lane Medical Library and the Stanford Medical History Center symbolizes the gap in our awareness of the similarities in the medical school experience that course through time. We hope that *H&P* can bridge this gap through “A Snapchat in Time” so that our readership can experience the lives of those who walked this campus before us.
FEEDBACK ON FEEDBACK

SASI MADUGULA

STANFORD—Students at the Stanford School of Medicine will wake up next week to find new assignments on their CourseWork websites. “Feedback on feedback is a valuable way for us to ascertain the efficacy of our class feedback forms. By asking students what changes they would make to feedback forms, we can further improve the quality of feedback at Stanford Med,” said a university official spearheading the program, who spoke on the condition of anonymity.

According to several sources, the feedback on feedback forms, or “Meta-Feed” as the project is affectionately called by its proponents, will involve “innovations in feedback, the likes of which have never been seen before.” These will include requiring feedback on font size, textbox width, and background color. Feedback opportunities on individual questions will also be provided, inviting students to rework answer-choices’ grammar, diction, and meter, to make them completely unbiased while equally appealing through subtle uses of alliteration and poetic devices such as iambic pentameter. The feedback provider will then retake combinations of the aforementioned questions and again rate their feedback experience. Additionally, the “keep, stop, and start” paradigm will be implemented to “tie things nicely back to integrate the curriculum,” the official said.

While feedback on feedback is intended to be an enjoyable experience, the Stanford School of Medicine believes that curtailing the autonomy of its students to ensure acquiescence with essential professional duties is important. “In order to ensure complete and total compliance with this very important policy,” the official continued, “we will deactivate university and medical school IDs, forbidding access to the 4th floor, gyms, and other facilities until all students have completed the forms. The idea here is to demonstrate that we are very serious about improving the feedback experience for students.”

No word as to when feedback on feedback on feedback, rumored to be in the works, will be released.

No students could be approached for comment.
September 28th, 2013 marks the first annual SMS cup, a field day for all SMS students involving some friendly competition between various Educators-4-CARE groups. Competitions included banner making, capture the flag, a corn eating contest, a bucket-filling relay using sponges, and trivia. Team Green (which included groups under Drs. Basaviah, Bronk, Chen, and Taleghani) walked away with the trophy.
Q and A with Emily Lines (SMS II), a key organizer of the first annual SMS cup:

Q: What was the inspiration for the SMS cup?
A: The inspiration for the event came from a desire to promote wellness at Stanford from the student’s perspective - to build something fun for ourselves, to build community, to get outside, to welcome first years.

Q: Tell us about the events.
A: My favorite event of the Cup was the corn eating contest - we got to see a lot of buttery corn flying and some delightful, herb-filled toothy smiles. I think people had the most fun during the water relay, where we used sponges down a relay line to take water from one bucket across the lawn to another. The water was a great way to cool down on a hot day and everyone got super competitive.

Q: What was the prize?
A: The prize was a pretty grand trophy with a SMS Cup Champion title printed from a label maker - plus tons of bragging rights - OK, so that’s an area for improvement next year!

Q: What are the plans for SMS cup next year?
A: We are definitely planning to hold the event next year. The event has a lot of room to expand and it all stems from student initiative, so we can mold it into whatever we see for the future. I had a great time organizing it this year and I really encourage others to get involved in the years to come!
SMS AROUND THE WORLD

Michael Hole (SMS V and MD/MBA candidate) lived in Haiti for a year working on a project which evaluated the impact of a Stanford-sponsored neonatal resuscitation curriculum on maternal and infant mortality in rural developing world settings. *(Above and Left)*

Diana Huynh (SMS II) did a traveling medscholars in Dhaka, Bangladesh. She shadowed at the International Centre for Diarrheal Diseases, Bangladesh and worked on a cross sectional project to understand if there is any relationship between the maternal age at marriage of mothers and the malnutrition level of their hospitalized child. *(Below)*

*Above:* Farmer by day, student by night in Malawi.

*Below:* Bhutanese superheroes “can change the world!”

*Below:* During one of her weekend trips, she captured this photo of wetland fisherman in Srimongol, Bangladesh.
Jake Rosenberg (SMS V) saw patients at a clinic in San Lucas Toliman, Guatemala. (Above and Below)
Trishna Narula/Victoria Boggiano: What was your childhood like?

Charles Prober: My childhood was very happy. I grew up with two older brothers and loving, supportive parents. Unfortunately, my father died when I was 14, so I didn’t get to know him as well as I would have liked, but my mother was wonderful and my brothers were very supportive.

TN/VB: What made you decide to go into medicine? Did you always know you wanted to be a doctor?

CP: I didn’t give a lot of thought to my career path. I was enjoying spending time at the YMCA as an assistant physical director and playing football. The first thought I had was, “Well, maybe I’ll become a lawyer.” I started college with that intent. I do not remember the Eureka! moment when I said, “I want to be a doctor.” There are no doctors in my family, but I decided that I wanted to go to medical school. I found out what the courses were, and then in the second year of college, I did the pre-med stuff. It must have been more common back then to be admitted to medical school without a degree, so I went to medical school just with the pre-med courses and no undergraduate degree. My wife points out all the time, “You have no degree!” I correct her, I have an MD, but I must admit that I did not graduate from college.
TN/VB: What made you decide to specialize in pediatrics?

CP: I spent a lot of happy days working with children at summer camps and the YMCA. In medical school, in clinical rotations, it was a population that really resonated most with me. There was a faculty member who was the father of one of my classmates and a well-known pediatrician in the town I was in who really resonated with me – he wore bowties too – so he was sort of a role model. So I was pretty sure, if not positive, that I wanted to go into pediatrics. Back then, when you did your internship, you could mix and match specialties. So I did a mixed-major pediatrics, which means that in my internship I did 8 months of pediatrics and 4 months of internal medicine. During internal medicine, I liked the patients… but not nearly as much as children.

TN/VB: How did you decide to sub-specialize in infectious diseases?

CP: Infectious disease is a very broad specialty. It is not focused on any specific organ of the body but rather is focused on the entire person. It also has a mystery, which is often solved or was once often solved. When you have a patient with a typically acute problem, you do the appropriate workup, come up with an answer. And then for many infectious diseases, there is a treatment that follows the answer. The infectious disease faculty member at the place I was doing my residency training was amazing. I respected his breadth of knowledge and approach to patients. He was the world’s authority in urinary tract infections, and he would be called by people all over the world for guidance about how to design a study or how to treat a particular patient. Having that niche and that authority feeling useful to a large segment resonated with him and resonates with me.

TN/VB: What made you decide to leave Canada and begin practicing medicine in the USA?

CP: I knew that I wanted to end up in an academic environment, and others said, “If you’re going to be an academic physician, first you should be a real doctor.” So after two years of core pediatrics, I stepped out of the program I was in and found a small practice in rural Oregon that had no pediatrician with the intent to be there for a year.

Then I finished my residency at UCSF, which was absolutely fortuitous. I met my wife (Laura Bachrach) at UCSF. She went to medical school in Boston and came to be an intern at UCSF when I became a senior resident. After finishing my residency, I wanted to train in infectious diseases, and Stanford was just starting a Pediatrics ID fellowship program. I interviewed for that and was accepted. So that made the move easy – San Francisco to Stanford. Then I started to get itchy feet for being back under the Canadian flag so when I finished training, I went up to Toronto. I was getting married at that point in 1979 and moved to Toronto with my wife who was training in endocrinology. We were up there for a number of years. We had both children in Toronto, one in 1983 and one in 1985. We came back in 1985.

TN/VB: What made you decide to come back?

CP: We were very happy in Toronto, but the person who

Dr. Prober by the Numbers

Age: 64
Years in medicine: 44
Years married: 34
Children’s ages: 30 & 28
Number of working hours a day: 10-11
Number of sleeping hours a day: 7
Alarm clock on weekdays: 5:15am
Alarm clock on weekends: 5:15am
Days spent traveling in one year: 30
Bowties owned: >60
Donald Duck impressions done in one week: 0 to ∞
oversaw the pediatric infectious diseases division here died suddenly and unexpectedly. I was recruited back by my friend and colleague, Dr. Ann Arvin (now, Vice Provost and Dean of Research for Stanford University). My wife and I created a list – reasons to stay in Toronto and reasons to leave Toronto, and the list favored staying in Toronto. Then we proceeded to disregard the list and decided to come back to Stanford. At the end, it’s the gut reaction. So we came back in 1985 with a 2-year-old and a newborn and have been here since.

TN/VB: What has been your favorite part about being a dean at Stanford? What have been some of the challenges you’ve had to overcome while here?

CP: My favorite part is talking to, working with, and being able to shape the next generation in medicine, from medical students through residents through fellows and even junior faculty. It’s tremendously rewarding and extraordinarily stimulating, like vicariously living through other people at different steps in their career. Having conversations with bright young people or even bright old people is fun! Being in a position to influence changes in medical education is a tremendous opportunity and privilege.

In terms of the biggest challenges, it is frustrating when I see something that I believe needs to be changed but cannot be changed fast. The need to set boundaries in my own expectations about the pace at which changes need to be made or can be made has been a source of general frustration. But any struggle is far outweighed by the opportunities that exist, the development at the school, and my personal development for that matter.

TN/VB: Speaking of development, what do you see as the biggest upcoming change in the next five to ten years in education, in healthcare delivery, and at Stanford?

CP: I think Stanford is in a unique position to impact changes broadly across medicine. That means patient care, research, and education. It’s just amazing what our environment has – for example, two Nobel Prizes in the School of Medicine...and that’s just this week.

Looking at patient care, the need to change the method of healthcare delivery is profound. It frustrates me that the conversations that come out of Washington and the political debates talk about protecting the best healthcare system in the world. I ask why they think we have the best healthcare system in the world because I really don’t think that we do. If you look at metrics in terms of infant mortality, life expectancy, survival from disease, we do worse than most developed countries. If you look at disparities in healthcare delivery, they’re atrocious. To have 35 million individuals uninsured is crazy. I grew up in the Canadian medical system where everybody has access to healthcare. The US healthcare system has a long way to go, and the delivery of healthcare in our environment has opportunities for improvement. As I look around and see how hospitals are trying to reinvent themselves, I’m very positive because they’re focusing on patient experience in addition to many other things.

In terms of research, it’s clearly boundless. You look at the Nobel Prize laureates and the remarkable basic science discoveries taking place in our own backyard – literally. The stem cell building that just rose from the ground has groundbreaking research in stem cell biology. Our faculty is the most successful at getting NIH grants to support their research. We attract...
students who are very interested in pushing the envelope of discovery not only in the basic sciences but also in all forms of discovery. We’re sitting in the middle of a university that also has other remarkable schools that we can tap into: Schools of Engineering, Business, Law, Education. You put that in the center of a valley that just bubbles with innovation. We’re in the absolute sweet spot for discovery on all levels.

In education, we have tremendous opportunities to change the whole paradigm of medical education. We have a small class of students, which means we can introduce things more easily. Many of you are interested in helping to change the educational paradigm and are willing to participate in that endeavor, whether by making videos or opining about what education should be like. We have the opportunity to connect to technology that can support education in a way that no one else can. The role of online education or online delivery in education has grown from this community and we have ready access to expertise across the University and at Google, Apple, Khan Academy, Coursera, and EdX. We can introduce new educational innovations into a relatively small class, make material more compelling, whether through flipped classroom or simulation, and deliver a product that should be a model for what others can do. So my agenda for education is not only on behalf of Stanford but to have Stanford drive educational reform nationally.

**TN/VB:** How has medical education changed from when you were in medical school?

**CP:** Not much, which is part of the issue. In 1910, Flexner published the Flexner report and said medical education in the United States has to have scientific basis. When he did his analysis of schools across North America, he concluded that we should have two years of preclinical education and after that, clinical education. That was 1910. So the model of medical education still makes sense but perhaps it is not as segregated as it was back in the day. When I went to medical school, it was still two years of preclinical and two years of clinical. My gross anatomy course extended through the entire year, and we dissected everything. It was engaging and important but way too big a dose of anatomy. So there have been modifications in the dose of this and the dose of that, and there has been massive change in the types of material that need to be taught, but more or less, the overall structure of the curriculum is similar. We should be teaching less at the core to lay the foundation, and allowing the growth from that core to be driven by an individual student’s passion as opposed to trying to teach everything. I wrote a paper with Sal Khan about this called “Reimagining Medical Education.” A reason for changing is to try to make the journey of education more powerful and to make the lessons more sustainable and stimulating.

**TN/VB:** What is one piece of advice that you have for preclinical students and one you have for clinical students?

**CP:** For both, savor those moments where you are. Even...
if it feels hard to learn what you’re learning, recognize that this is towards your developing into a physician. Don’t feel like you need to be the best in your class. Just do it because you’re aiming to develop yourself to your best personal abilities. In the clinical realm, decide what you’re looking for in yourself as a physician and make that your priority. Don’t worry about not having the most comprehensive and up-to-date knowledge in a specific discipline. Do worry about making a difference in the lives of the patients you are privileged to work with. Aim to help them in any way that you can.

**TN/VB:** How do you balance work, family, health, and everything else in your life?

**CP:** A priority for my wife and me has always been each other and our family. In terms of fun, I like golf, exercise, and reading. We try to spend time in different places locally, San Francisco, the Monterey area. That’s an attempt at balance. I do work long hours because I enjoy it. My wife and I have been very bad about taking vacations. We went away with our family once or twice a year for medical events at which we were speaking, which was very cost-effective. When we were actually going on a regular family vacation without a medical meeting, I was shocked at the expense!

**TN/VB:** What are your kids up to now?

**CP:** Thank you for asking. We are very proud and close to both of them. Our daughter Meghan is the elder. She went to Harvard as an undergrad. Then she came back to the west coast, taught for a couple of years, worked for March of Dimes, and now works at a start-up in San Francisco. Our son Andrew went east to Oberlin. He came back to the Bay Area and is now deeply embedded in an inner city high school in Oakland called Fremont High. Disparities in educational opportunities certainly play out there. There’s gang violence on campus, and it’s a very difficult environment, but he really feels that he’s reaching students in a very meaningful way. He’s teaching close to 25 classes a week, and if you look at teachers in the public school system, that’s what they all do.

**TN/VB:** Can you tell us a joke?

**CP:** An internist, a pediatrician, a pathologist, and a surgeon go duck hunting. They’re in this little bluff where you wait for ducks so you can shoot them. Something flies over the bluff, and the internist stands up and listens and says, “They look like ducks, they sound like ducks, I better get a consultation to determine if they’re ducks,” and by that time the ducks are gone, so he gets zero ducks. The pediatrician is in the bluff, and he’s up next. He looks up and says, “Oh, those are so cute, they look like they’re probably ducks, oh boy, oh boy, oh boy!” And by the time he’s finished, the ducks are gone, so he gets zero. The surgeon gets up with a sub-machine gun, and he just blasts everything in sight. Hundreds of birds fall to the ground and he turns to the pathologist and says, “Now you make sure those are ducks.”
Dr. Preetha Basaviah is a Clinical Associate Professor of Medicine at the Stanford School of Medicine as well as the Course Director of the Practice of Medicine course taken by all first- and second-year medical students at Stanford. She has been an Educator for CARE (E4C) since the conception of the program in 2008. Dr. Basaviah received her bachelor’s and medical degrees from Brown University and pursued her residency and fellowship at Beth Israel Hospital, serving as the Chief Resident. She was one of the first Fellows in Medical Education at the Beth Israel Deaconess center and she has won numerous awards for teaching, including the National Award for Scholarship in Medical Education granted in 2011 by the Society for General Internal Medicine.

Sarah Waliany: Why did you decide to pursue medicine?

Preetha Basaviah: From a young age, I wanted to make a difference in people’s lives and combine that with a passion for science. Early on, having tutored and worked in a lab, I realized that there would be a wonderful combination of teaching, research, and science in medicine. However, I also wanted to make sure I could have a broad, liberal education and be an effective communicator.

The Brown 8-year medical program seemed to be an ideal match for this, and I’ve stayed really connected with that community over the past 20 years. I currently serve on the board of the medical school
there. Similarly, staying involved with students and trainees at Stanford is energizing and gives me a sense of renewal.

SW: You’ve been a part of the Educator-4-Care (E4C) program since it first started in 2008. What led you to become an E4C and what has your experience been like in this role?

PB: The E4C program has been incredibly affirming and inspiring for me. Most importantly, it created a learning community which brings together like-minded folks, both trainees and faculty, with the common goals of developing mentoring relationships, teaching clinical skills, developing professional identities, and learning from one another.

SW: You’ve had an incredible influence on your students. What inspired you to enter teaching?

PB: Seeing students’ faces light up when they had their “aha” moment stays vivid in my mind as an inspiring early experience. This is similar to becoming a mom and teaching my children to ride a bike or helping them read. From the medical point of view, I feel that we’re a team, and that we’re investing in generations to come. It gives me incredible satisfaction to know that all of you will be taking care of me one day. I hope that we’ve done right in teaching you the framework, knowing that you will continue to grow and be leaders and healers in medicine.

As faculty, we learn a tremendous amount from our patients as well as from all of you. Questions (from patients and students) are a wonderful opportunity for
us to relook at what we’ve been teaching, to go back to the literature, or to ask our colleagues across the nation who may have encountered similar challenges.

Each year, we say, “This class is remarkable.” I think this is because we genuinely find the unique characteristics of each student and of each class. Seeing that reciprocal dialogue and learning is one of the unique things about teaching that must continue to drive folks over the long term to give them the energy to do such meaningful work.

SW: Can you describe how the Practice of Medicine course came about at Stanford?

PB: Dr. Braddock came from University of Washington about a decade ago, with the charge of taking the clinical skills training to the next generation. When I was recruited in 2006, it was with the notion that the practice of medicine course should involve all the elements of what a physician would need to consider when taking care of patients: clinical skills, ethics, nutrition, policy, interpreting literature, epidemiology, information literacy, plus hands-on experiential learning in real workplace settings. Some schools call these the “pre-clinical” years but we call it “pre-clerkship” because we incorporate the clinical component early.

SW: How has teaching in POM impacted you in your own patient care?

PB: The E4C’s and I have grown tremendously. In the beginning, we did a faculty development course with the American Academy of Communication and Health Care, and we learned about the feedback model of “keep, stop, start.” POM reinforces the importance of looking at communication really deeply: eye contact, tone of voice, and process comments while incorporating empathy as we gather information systematically, share information with patients, and manage issues.

In terms of the physical exam, being an E4C re-emphasizes the basics, including listening with the stethoscope on the skin instead of over the gown, positioning the patient correctly, integrating a caring, patient-centered approach, and [maintaining] a really structured and effective flow of the exam. I’m grateful for that because it’s like muscle memory: it becomes part of our routine. No matter how hectic things are, my body can take over to make sure I stick to those physical exam ideals.

SW: What have been your most memorable moments as a physician?

PB: I still remember my first patient who passed away. The patient had inflammatory bowel disease, complicated by primary sclerosing cholangitis. I was the least experienced on the team because I was a new clerkship student, and I felt I was not able to provide anything. I learned however, that I could be a source of constant support for the patient and his family: listening to his stories about his sons, hearing about all the things he’d done in the world. My colleagues and attending taught me to keep in touch with the family after he passed so that they would not feel abandoned. I teach that to this day to my team. My teams and I have called families, sent a sympathy card, or have attended special ceremonies. Patients and their families were very grateful and the patient-caregiver bond was strengthened.

A year later, when I was a senior medical student, one of the family members saw me in the hospital, and they thanked me. That connection was so pow-

“When in doubt, go back and reprioritize what your core values are so that you always feel like you’re grounded no matter what you do.”

Leaders In Medicine
erful that I remember it 20 years later. And that’s not something you can say about all professions.

Bottom line: a career in medicine has made me humble, grateful, and inspired. The courage that patients show, their emotions, and their stories have made me so grateful for every day and every experience, and make me realize the importance of taking care of oneself.

**SW:** How do you balance your personal life with your career?

**PB:** I like the term “work-life flexibility.” To me, this means: 1) defining your priorities, 2) knowing your team and resources so you can achieve those priorities, and 3) finding what you are most passionate about. Sometimes the adage that “you can have it all but not necessarily all at the same time” is true. Sometimes you feel guilty because you can’t do it all. For me, right now it’s family, work, and wellness. You can’t take care of others if you can’t take care of yourself.

I am a firm believer in teams and resources. I have a supportive partner – my husband – who is a venture capitalist. My mom lives with us, my brother visits often, and I have wonderful, loving nannies. Like they say, it takes a village. It brings its own level of complexity, but it’s worth it for me to make sure that we’re all members of a family helping one another. You have to flex up and down in your job description at times. When I was younger, I didn’t realize there would be this constant momentum of flexing up and down. It’s helpful to talk to people a few years ahead of you about strategies – learning tips about different listservs, playgroups, and such.

**SW:** As you mentioned, in the past, work hours were longer and decreased in quantity. Some physicians are in favor of
that and others are not. What is your take?

**PB:** I think that duty hours are important in being able to restore priorities. As clinicians we need to be at the top of our skills when caring for patients, and need to have slept, eaten, and have our health in order.

When I trained, we had 24-hour call and had to be there the next day. There were no duty hours. I remember taking quick cold showers to wake up; it feels like the prehistoric ages. This generation has different challenges and opportunities.

One challenge is how to provide trainees who are doing shift-work with enough longitudinal experiences. Clear and educational hand-offs are important, and it requires more investment and guidance about how to glean all the teaching points that might have happened if it had been you who was there for 36 hours doing all of that patient care. Our training program is addressing this by having in-depth, structured sign-out rounds where members of both shifts’ teams come together to understand the patient care events. Furthermore, the attendings are encouraged to review notes and give feedback to the team member who went off shift (to help build those connections regarding management decisions).

People perceive that the trainees don’t have as much invested in patient care due to “shift work mentality.” I believe that trainees are as invested. They often go home and check in on the computer to find out how their patients are doing. It’s natural that we are inquisitive and may have our questions and want to do additional inquiry.

The different programs have come up with different ideas (relating to shift work), e.g. rounds at night and rounds in the morning. That’s your time to learn, have some focused teaching, and be caring directly for patients. It’s a real culture shift.

**SW:** What are some challenges that you have faced in your career?

**PB:** One challenge is balancing the excitement of a lot of opportunities and knowing the right time to pursue them. I really enjoyed being one of the first two hospitalists at Beth Israel along with esteemed colleague, Joseph Li, in a program led by Dr. Mark Aronson, and it was a special privilege to be one of the first medical education fellows at the Harvard Institute for Medical Education. We had very long hours as the first hospitalists, trying to figure out what would be the right ratio of faculty to patients as we developed the new system. We expanded the program from 2 to 4 to 8, and now there are over 40 under the leadership of Dr. Joseph Li.

Another challenge is reprioritizing goals along the way. I did a lot of travel early in my career. I ran national meetings, chaired national education committees, and enjoyed learning so much from my colleagues. Once I became a parent, I realized I had to pick and choose those conferences where I would actively present or direct sessions.

The profession of medicine is very nurturing for younger faculty [members] to take chances and to try new leadership opportunities. I’m not so sure that this is true for other professions. My approach has been to be open with my groups, letting them know that family events and my teaching the team is a priority, so my priority is ultimately to work to find times for all of it. It’s been manageable in the academic environment that I’ve chosen. You may choose to do your clinical call time at times of the year when your kids don’t have as many activities and take your vacation when your kids have vacation. It requires a lot of advanced organization, but it’s all worth it.

**SW:** As a woman in medicine, have you faced any particular challenges?

**PB:** I feel that medicine can be quite supportive for women, and that we may need to think creatively or out-of-the-box as situations arise. For example, at a national meeting I was the course director, leading the curriculum and invitation of speakers for a year. However, my second daughter was due to be born during the same week of the meet-
ing, so I partnered with the upcoming course director who could be our voice at the actual meeting. My esteemed colleague, Alpesh Amin attended and guided the meeting and in turn did a lot of the behind-the-scenes work, including a welcome video a few days before delivering my second daughter.

Other challenges of being a woman in medicine may be charting territory where there were not as many female role models. In the leadership of a particular field, there may be role models, but they may not always be at your institution. I would encourage attending conferences, like Women in Medicine, since it allows you to hear advice, ask for experiences, and help with advocacy, negotiation, and faculty development.

For a woman, negotiation is an area of growth for many. I’ve taken faculty development workshops and learned a lot about negotiating for different job descriptions or acquiring resources for projects. One course was led by a woman who did drama and speech coaching; she had us jump up and down to find our deeper voice. We read quotes to each other and emphasized different parts of the quotes to get our meaning across. It was very illuminating. The challenge is about having your voice heard.

If you find a particular group has more men than women, find that balance of effective communication strategies. One strategy might be to lead with your conclusion and then see if people want to hear more of the supporting effects. Another would be using different voice octaves, especially if you’re new to the group or if there is an age or experience differential, in addition to not making a statements that sound like a question.

Work-life flexibility does not just mean families with children. It can also mean individuals pursuing outside passions, individuals taking care of family members who have health conditions – men or women. In this generation, new fathers have many responsibilities like the new mothers, where they also want to be with their child on paternity leave. We have to be creative, open and flexible so that people can take their individual paths and time requirements to reach a particular place in a career. This might mean that promotion timelines have to be different for individuals. I am very encouraged to hear that Stanford is continuing to focus on making the work and school environments more conducive to individuals’ needs.

SW: You’ve seen how medicine is practiced on the east coast and the west coast. Can you describe how medical practice is similar or different?

PB: The common thing is that people work tirelessly and are incredibly dedicated to their passions and goals in medicine.

It is helpful to learn from faculty at different institutions and to learn different regional practice styles. Another benefit of moving to a new institution for a new career step is that it’s a challenge to transition roles at a single institution. People may still see you in that prior role. When I became one of the first hospitalists at Beth Israel, one day I was a VA chief resident and then a medical education fellow. The next day I was in charge of patient care as the attending. If you were to go to a different institution from day one, people treat you as the new person doing faculty work.
In addition, as someone bringing experiences from another institution, you can bring diverse perspectives to new committees and projects.

**SW:** What are your interests outside of medicine?

**PB:** Twirling around the dance floor and swaying to the beat of all types of music make me excited and give me energy. I love to dance. I used to do ballet, jazz, and Indian classical and folk dance. So now I practice with my daughters. Watching movies with friends, walking the Dish, and doing other outdoor activities is a lot of fun. In this generation, when you want to catch up with a friend, we’ll do it as a walking catching up rather than sitting over coffee or lunch. I love to play tennis and it is a great family sport with my husband and three daughters (Divya, Sahana, and Avani of ages 11, 8, and 6, respectively).

**SW:** Looking back, is there anything you wish you would have known as a medical student?

**PB:** I was the eldest child of a first generation immigrant family growing up in this country. I followed a path that I thought was tried and true because I was less inclined to take risks. Looking back, I would have encouraged my 18-year-old self to take more risks, to travel, to do that semester abroad, and to try to more things outside of medicine. It is more challenging later to take time away. I try to inculcate those values in my children: if there are no challenges and no mistakes and everything is straightforward it means that you probably are not pushing yourself to that next level. Taking intellectual risks helps us grow stronger.

I like to use the metaphor of the tree. Each of us is like a unique tree: we can get advice, hear people’s stories, and then take the parts that are a fit for us. You have to share what your passions and hopes are, putting yourself out there and opening up the dialogue. By creating that network and having ongoing discussions and relationships, there may be increased opportunities over time. The trunk represents our core values and priorities. Each branch depicts the paths we take to help bring our passions to reality.

Early on, we are taught that one branch, scholarship, is about writing papers and publishing. In my career, however, particularly in my medical education fellowship, I learned that scholarship can be developing curricula, presenting at national meetings, developing guidelines. Other branches include networking, mentoring, teaching, and creating programs.

When in doubt, go back to the core trunk and relook at your core values so that you always feel like you’re grounded no matter what you do. The core values will likely not change over time, but your priorities may, depending on which stage of life you find yourself.

**SW:** Do you have any more advice that you want to give to your students?

**PB:** I want to say thank you to all the students for all their energy, creativity, compassion, and dedication. They inspire us. I feel that we’re partnering with them on their journey, and that’s a privilege for us. We learn every day along with them and that’s part of what makes our community so rich. Ultimately, we all have the same goals of providing outstanding care to patients and advancing our fields of science as well as contributing to the community in meaningful ways.

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