Her medical education started in New Zealand, brought her to Mount Sinai for her residency and took her to Peru for a prestigious training program in Infectious Diseases. Since then, Anu has held Associate professorships at both the Icahn School of Medicine at Mount Sinai and at our Master of Public Health Program. She has also traveled considerably in the last decade and has worked with international relief organizations to bring medications and health education to women and children in India, Uganda, Central and South America.

Many things could be said about Anu after having the pleasure of talking with her. She is certainly a trusted colleague and nurturing mentor, an avid traveler, a strategic and innovative thinker. Most importantly, she is a woman driven by her solid aspiration to improve health care for everyone, everywhere.

Read more to understand Dr. Anandaraja's experience, words of advice and sense of being for the next generation of Global Health Professionals, as part of our interview for The Rossi. Continued on page 8.

Alicia Orellana
MPH Year 2

Dr. Anandaraja, dearly known as “Anu” by faculty and students, is a world class physician in the field of Pediatrics. Active in the areas of international child health and disaster relief, she is also currently, the Director of Education at the Arnhold Global Health Institute. She oversees the development of global education programs and supervises projects with partner organizations around the world.

New Health care Guidelines for Gender, Sex and Sexuality
About Individuals who are LGBTQ, Gender Nonconforming or with Different Sex Development

Asta Man
MPH Year 1

Recently, new AAMC* guidelines have been implemented for health care providers aimed to better serve and integrate LGBTQ (Lesbian, Gay, Bisexual, Transsexual, Queer), DSD (Different Sex Development) and GNC (Gender Non-Conforming) topics into medical education and practice. Such issues are extremely important to people who identify within those parameters as they are often excluded, mistreated, ignored and even abused by the medical system - often based on health care providers’ own ignorance. The guideline defines the difference between sexual orientation, gender identity, gender expression and biological sex development; describes how to interact with these patients; how to understand the various risks and barriers associated with their identities and how one can develop and assess these topics in various educational settings.

Continued on the next page.

*Association of American Medical Colleges
First and foremost, the new guidelines describe the dangers of assuming patients’ identities. The default assumptions should not be ones of heterosexual and cis-gender, but rather an open approach for the patients to openly discuss their identity. Health care providers should understand gender and sex are not binary terms, but are actually a spectrum of identities that are unique to each patient. These narrow beliefs close doors for discussion about risks associated with specific identities (i.e. lesbians and bisexual women are more prone to inconsistent condom use) and create a hostile atmosphere for patients to discuss further discuss sensitive issues. Furthermore, assumptions may also lead to misinformation, such as: sexual orientation defining sexual history and/or experience, surgical and hormonal transition history and improper biological sex identification.

“Health care providers should understand gender and sex are not binary terms, but are actually a spectrum of identities.”

One of the most important issues is the significance of using the correct pronouns and language when interacting and referring to patients. Using the correct pronouns are key in forming a relationship with patients, as this allows the patients to feel welcome in environments that have a reputation to be hostile – for example, a study found that 1/5 of transgender patients were denied Health care. Open-ended questions like “Excuse me, what is your preferred pronoun?” or using gender-neutral pronouns like “they/them” will allow the patients to know they do not have to hide their identities and will encourage them to be forthcoming about their medical history. Access to a more elaborate medical and personal history allows Health care workers to properly administer counseling, tests and medicine.

Another key issue and barrier to Health care is medical language regarding genitalia and transition-related terminology. While there are medical specific terms for anatomy, laypeople are usually not familiar with these terms since they do no come up in general discussion. It is noted, not all transgender people undergo gender-affirming surgeries and/or hormone therapy therefore a transwomen may have a fully functional penis and do not want to call her penis by the anatomic word; this is something that health care providers need to be aware of and respect. Many DSD people have undergone unwarranted invasive and damaging interventions to ‘correct’ their genitalia, they are more prone to discomfort or even feeling violated during physical exams. Being specific and respectful when inquiring what types of surgeries patients have had will help to determine the risks that patients may be exposed to during their daily lives. Do not assume.

To remedy these neglected issues, the guideline provides a list of associated risks to specific branches of the LGBTQ, DSD and GNC communities along with specific case examples ranging from adolescents who may be questioning their sexual orientations and gender identities to non-gender conforming adults to gay male elders who are HIV+. This section focuses particularly on adolescent groups, because they are the primary target population for preventative medicine. It is believed that by introducing the adolescent population to support groups, creating an encompassing environment and helping them to understanding the risks early on, we will be able to lower the already elevated rates of depression, anxiety and suicidal behavior that accompanies adolescent populations of LGBTQ, DSD and GNC communities.

The guidelines also include suggestions on how to integrate LGBTQ, DSD and GNC topics into various stages of medical education– the administration/teachers, clerkship and residency. A study done in the US shows that only 3 hours and 26 minutes of the medical education is dedicated to homosexuality topics, with half of the schools having no curriculum at all. Solutions to integrate LGBTQ, DSD and GNC topics can be relatively simple, ranging from having inclusive case-examples to having class discussions lead by out-faculty about their experience with discrimination. The minimal curriculum points to a very important issue: lack of exposure. Students can only learn so much from reading and practicing what to say in front of their cis-heteronormative classmates; it is crucial for students to interact with LGBTQ/DSD/GNC Health care workers, patients, teachers and coworkers. The guidelines suggest incorporating lectures about trans-health taught by actual trans people and allowing students to observe how to respectfully perform a physical exam for people with DSD.

“...not all transgender people undergo gender-affirming surgeries and/or hormone therapy.

Do not assume.”

Lastly, the guideline also provides methods for evaluating health care worker’s knowledge on the topics. They range from role-playing scenarios to multiple-choice and short answer questions. As Health care providers, we need to identify and treat everyone’s identity with validity, un-learn any bigoted or misguided notions and share our findings. LGBTQ, DSD and NGP populations are some of the most neglected populations being treated today; health insurance may not cover their needs and people of color and/or women face added layers of stigma. It is our duty to ensure they too receive the highest levels of health care possible.

The full guideline can be read for free on the Association of American Medical College’s website (www.aamc.org).
Ban the Box: Confronting Discrimination in Hospital Hiring
On Behalf of Mount Sinai Organized Action

Leela Chockalingam (MS1), Krupa Harishankar (MS2), John Power (MS1)

Much has been said about the growing crisis of mass incarceration in our country, especially how it disproportionately affects people of color. And it’s true, the United States currently houses 2.2 million people behind bars, a greater percentage of the population than that of any other nation in the world. Sixty percent of those incarcerated today are people of color. Nonviolent drug offenses make up the majority of convictions, and people of color are three times more likely to go to jail for these offenses—not because of greater prevalence of drug sales or use, but rather due to more severe policing and sentencing. But, the consequences of racism do not disappear when an individual is released from prison. They are carried into the re-entry process and pervade the community. When the time comes to re-enter society, the prospect of meeting basic needs like food, housing, and employment becomes more difficult, and desperation leads to what’s known as recidivism, or relapse into imprisonment.

There needs to be more action taken by partnering up with workforce intermediaries—to stop perpetuating institutionalized discrimination and systemic racism.

There needs to be more action taken to be in favor of fair hiring practices, and partner up with workforce intermediaries—to stop perpetuating institutionalized discrimination and systemic racism.

In medicine, we hope our interventions will both diminish symptoms and target the source of a problem. For a moment, consider mass incarceration as a disease. Providing employment is an intervention that would accomplish both aims. Statistics show that formerly incarcerated people who were consistently employed throughout the year had a 16% recidivism rate, compared to a 52% recidivism rate for all other Department of Correction releases. Employment allows individuals to provide for themselves and also reduces the symptom of recidivism. But something stands between the formerly incarcerated and gainful employment: the box.

It’s a small square that asks a big question: have you ever been convicted of a crime? All potential employees with criminal histories must check the box. And too often, regardless of the crime and its relevance to the position applied for, it is enough to remove a qualified applicant from consideration. Though it was designed to notify employers of specific criminal records that could compromise the needs of the position, employers often see a checked box and throw out the application without further investigation. This type of hiring discrimination is illegal, but is so hidden that it is impossible to enforce by any legal authority. Ultimately, the box turns any criminal record into a life sentence by preventing gainful employment and creating the circumstances for recidivism.

The box also reinforces pre-existing racial prejudices. Research shows that 17% of white applicants with a criminal record were later contacted about a callback interview. In comparison, 14% of black applicants without, and only 4% of those with a criminal record received a callback.3 Indeed, the percentage of black applicants without criminal records who received a callback interview was lower than the percentage of white applicants with criminal records that received a callback interview. Statistics like these demonstrate two intertwined types of discrimination: one against formerly incarcerated individuals and another of systemic racism against African Americans. An employer’s interpretation of a checked box varies with the applicant’s race, disproportionately penalizing people of color. Beyond the obvious discrimination against all formerly incarcerated individuals, the box creates another avenue for racist hiring practices in our country.

Research shows that 17% of white applicants with a criminal record were later contacted about a callback interview. In comparison, 14% of black applicants without, and only 4% of those with a criminal record received a callback.3”

New York City Council is currently considering legislation called the Fair Chance Act that proposes to remove questions about criminal history from the initial job application. This follows the pattern of many cities and states across the country that have already enacted similar “ban-the-box” legislation. Banning the box prevents employers from asking about an applicant’s criminal history before the applicant’s qualifications have been considered. After a conditional offer of employment has been extended, the employer can run a background check and ask the applicant for information about convictions relevant to the position.

Basically, banning the box allows people with criminal records to have their qualifications assessed just like everyone else. It allows formerly incarcerated individuals to earn a livelihood, fills positions with qualified employees, and begins to eliminate the institutionalized racism that permeates our society. We need our hospitals to reform the way formerly incarcerated applicants are hired. No hospital is better poised to champion this cause than the Mount Sinai Health System. With 36,000 employees, Continued on the next page.
Mount Sinai is now the largest non-governmental employer in New York City. Furthermore, Mount Sinai has a real opportunity to match the employment needs of formerly incarcerated individuals because its health system has locations in many of the neighborhoods most affected by mass incarceration. Unfortunately, few hospital systems have taken strides to remove the box from their applications, and also lobby to be exempt from ban-the-box legislation. Hospitals often raise these concerns:

A) Hospitals worry patient safety will be affected by hiring the formerly incarcerated. However, pre-existing laws already require background checks and prevent people with compromising convictions from working in patient care. The Fair Chance Act does not change these requirements. Still, many positions in a hospital don’t involve direct patient care and can be responsibly filled by a formerly incarcerated applicant. For example, a person convicted of identity theft would not be permitted to work in a position with access to secure patient information, but can easily be employed in a field like hospital catering.

B) Hospitals do not want to be held liable for the potentially compromising actions of formerly incarcerated employees. But, a past criminal record does not make an employee inherently dangerous! Furthermore, background checks, conducted after a conditional job offer, would screen out applicants who pose such liabilities. Thus, in the rare event of a lawsuit, employers would not be found negligent.

C) Some hospitals are concerned that formerly incarcerated employees are bad workers, which hurts the bottom line. But employers who do hire people with criminal records find that they work harder and stay at a job a lot longer. For example, the Johns Hopkins Health System reviewed the employment files of nearly 500 of their formerly incarcerated employees and found that these individuals had significantly higher retention rates as compared to employees without a criminal record.3 It’s clear that efforts to ban the box are critically necessary. But even if we were to hypothetically remove discrimination from the hiring process, many formerly incarcerated applicants would still face an array of barriers including inadequate job skills, lack of familiarity with the application process, and reluctance to apply for fear of discrimination or lack of job experience. These complex needs have led to the development of ‘workforce intermediaries’ - non-profits that provide job skills training, job placement assistance, and career development counseling, linking formerly incarcerated individuals with employers. These intermediaries also respond to the needs of employers, assisting them by pre-screening applicants and guiding them in claiming government tax credits.

Mount Sinai has a real opportunity to match the employment needs of formerly incarcerated individuals because its hospital systems in many of the neighborhoods most affected by mass incarceration*.

Only a couple of hospitals such as the Montefiore Medical Center and Johns Hopkins Health System have built partnerships with workforce intermediaries. Despite the more widespread success of workforce intermediaries in reducing recidivism and facilitating employment in other sectors, the vast majority of hospitals have not taken advantage of their services. This needs to change.

As doctors-in-training, we frequently limit ourselves to effecting change within the narrow confines of the clinic. While we learn that albuterol can treat asthma and intubation can open airways, we lack the education to heal the social and political diseases of a nation that cries out “I can’t breathe.”

We would like to propose a new standard of care: we as students within a medical community must collectively leverage the institutions we comprise – hospitals – to roll back discrimination and institutionalized racism. To do this, students should become educated about the hiring practices of their local institutions, and start talking to other students, care-providers, and administrators about how to better support fair-hiring practices at their hospitals and medical schools. As Icahn School of Medicine students, we can sign on to the Sinai Petition for Intentional Hiring to push the Mount Sinai Health System to institute policies of fair hiring that include:

1) Pledging to respond to the needs of formerly incarcerated applicants by working with workforce intermediaries specific to their respective neighborhoods, and

2) Releasing a public statement explaining the policy change and support for non-discrimination.

Moreover, as students in New York City, we can play a key role in advocating for hiring reform in the health sector through coordinated outreach to our city council people, Dan Grodnik and Melissa Mark-Viverito. Students should look out for an organized opportunity to speak to legislators. We can encourage legislators to include Mount Sinai in the Fair Chance Act by:

1) Removing the box from Mount Sinai job applications, and

2) Inserting a statement informing applicants of their right to not be discriminated against based on a past criminal record.

Continued on the next page.
As community institutions and centers of healing, hospitals should lead efforts against discrimination based on both race and history of incarceration. It’s time that we as medical students claim our role as stakeholders in our hospitals, and assume responsibility for discrimination in our communities. In recent public discourse, the non-discrimination in our communities. In hospitals, and assume responsibility for claim our role as stakeholders in our hospitals. It’s time that we as medical students advocate and take action within our hospitals and home institutions. In doing so, we will begin to eradicate the disease of discrimination that continues to plague our country.

MSOA bio: Mount Sinai Organized for Action is a group of students that is committed to opposing systems of injustice that produce gross inequities present in our society. We recognize that the Health care system is complicit in perpetuating health inequalities. As students in the medical field we believe that we are in a unique position to work against actors who perpetuate inequality in the Health care system. If you would like to become part of our network or learn more about our efforts, please get in touch with an MSOA member.

References

You Got into Medical School to Become a Doctor, But Now What?

Moe Hissourou
MS1

Pre-medical students spend much of their college career dreaming of being a physician without realizing that different specialties can lead a drastically different life. When we reach medical school, the truth becomes clearer. Specialty choice affects many factors in our lives such as income, work-life balance, and prestige; as such, medical students are encouraged to spend their first year exploring different specialties in order to find the perfect match. Yet, for the competitive residencies that range from dermatology to orthopedics, extensive research experience specific to the relevant field is pivotal for a competitive residency application. And so, first-year medical students are presented with a dilemma: we must explore specialties as much as possible, while also participating in specialty-specific research in order to demonstrate interest in the field.

“...there are many factors that will influence your happiness as a physician such as income, work-life balance, and the physician-patient relationship.”

I acknowledge that it is difficult to reconcile spending time exploring careers with choosing a specialty-specific research project in order to become a competitive applicant. However, my goal here is not to provide my thoughts on a definitive solution for this dilemma: residency directors need some basis upon which to decide between competitive applicants and demonstrated interest in the field is still important. Still, there are some important considerations in choosing your approach to your first year as a medical student.

It is important to keep an open mind when considering a specialty -- deciding on a specialty too early can affect the way you perceive your experiences with other specialties thereby dissuading you from a specialty you might otherwise have loved. As such, try to get as much exposure as you can to specialties that you find interesting. Dr. Brett Miles in the Mount Sinai Otolaryngology department spoke on a method of exploration that he found useful -- for each specialty, try to do the following: see any procedures or surgeries done in that specialty, Continued on the next page.
You Got into Medical School to Become a Doctor, But Now What? [cont.]

shadow physicians in as many different settings as possible, take call with a resident and check out research in that department. After completing those steps, you’ll have some understanding of your interest in the specialty. Of course, there won’t be enough time during the beginning of medical school to complete these steps for all of the specialties and sub-specialties out there. Instead, try to be selective about which specialties you choose to spend a lot of time exploring.

One factor to consider is which specialties you will not see during your third year; for example, here at Mount Sinai, you are not required to participate in a radiology-focused rotation. As such, you may want to spend time exploring radiology during your first two years at medical school. Additionally, try to think of how you like to spend your day – if you enjoy working alone, you may want to spend time exploring specialties where patient contact is minimal. Lastly, be aware that there are many factors that will influence your happiness as a physician including income, work-life balance, and the physician-patient relationship. In addition to shadowing and research experience, try to build a ranked list of the factors that will influence your personal happiness and match specialties accordingly – keep in mind that the nature of specialties can change depending on the setting; working in a private setting and working in an academic setting will have different hours and lifestyle and different patients.

This amount of exploration will take a lot of time; be sure to make it a priority in the beginning of medical school while you have the time to do it. Also, be sure to read articles about different specialties to gather other people’s thoughts. Finally, be sure to enjoy your time in medical school! You’ve entered an incredibly rewarding profession with the opportunity to make a difference everyday.


Book Corner: “Being Mortal” by Atul Gawande

Medicine and What Matters in the End

Dr. Gawande is also co-founder and chairman of Lifebox, an NGO to implement systems and technologies to globally reduce surgical deaths.

Brian De
MS2

We are well-aware of the finite nature of all living things. Despite our cognizance of death’s inevitability, however, humans have lives filled with meaning, whether through self-improvement, personal relationships, or the pursuit of societal advancement. However, as a person ages or becomes very ill, these pursuits become more difficult or even impossible. Indeed, this phenomenon is particularly apparent in assisted living communities or nursing homes for the elderly, whose primary purpose has historically been to ensure the safety of their residents. But should ensuring safety be the only goal?

Atul Gawande is a surgeon at Brigham and Women’s Hospital with an interest in public health issues. For almost 20 years, he has authored articles in Slate and The New Yorker and written books covering topics related to medicine and the state of Health care in the United States. With his latest work, Being Mortal, he addresses how we can better deal with aging, chronic illness, and death. Several of the themes he writes about are briefly profiled below.

On being elderly in America: Gawande discusses the stark difference between aging in America versus aging in India through two examples: his wife’s grandmother, who lives alone in America as a widow, and his own grandfather, who lives in India. Though they both experience the debilities of old age, he notes that the elderly in India are not seen as a burden but rather as people who are highly respected and always supported by their large multigenerational families.

In America, he points out people are often left to live alone and fend for themselves. If they cannot, they are often relegated to retirement communities, assisted living facilities, or nursing homes, places where many residents cite high levels of dissatisfaction. Many are forced to spend their life savings to stay in such communities. He quotes: “our elderly are left with a controlled and supervised institutional existence, a medically designed answer to unfixable problems, a life designed to be safe but empty of anything they care about.”

On individuals’ goals near the end of life: Gawande refers to the ideas of psychologist Abraham Maslow, who describes the hierarchy of people’s needs: from basic for survival and safety, to love to desire for self-fulfillment. 

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While few would dispute survival and safety’s importance, Gawande notes “people readily demonstrate a willingness to sacrifice [these] for the sake of something beyond themselves, such as family, country, or justice.”

In addition, he cites the work of Stanford psychologist Laura Carstensen about personal and selfless desires which vary tremendously between individuals. For those approaching the end of their lives, Gawande proposes the following four “vital questions” to clarify these goals and inform decisions regarding care and treatment: (1) What is your understanding of the situations and potential outcomes? (2) What are your fears and what are your hopes? (3) What are the trade-offs you are willing to make and not willing to make? (4) What course of action best serves this understanding?

“Our elderly are left with a controlled and supervised institutional existence, a medically designed answer to unfixable problems, a life designed to be safe but empty of anything they care about.”

On difficult conversations: Gawande acknowledges the reasons why conversations about terminal illness can be difficult: “They can unleash difficult emotions. Handled poorly, the conversations can cost a person’s trust. Handled well, they can take real time.”

Given the difficulty of talking about death and dying, even among family members, it is often unclear what a patient’s wishes are— even with advanced directives. Physicians and other Health care providers can often be instrumental in not only helping patients to understand their current state of health, but also other potential options. Gawande believes the best approach is “interpretive,” one that allows both the patient and the provider to craft solutions based on the goals of the patient.

On the role of palliative medicine: Gawande talks about a phenomenon first by psychologist Daniel Kahneman called the “Peak-End rule.” Backed by empirical evidence, the theory suggests people do not remember events as merely averages, but rather by its more intense moments (“peaks”) and the resolution (“end”). Gawande provides the example for this: “Why would a football fan let a few flubbed minutes at the end of the game ruin three hours of bliss? Because a football game is a story. And in stories, endings matter.”

Gawande believes the “Peak-End rule” can also be applicable to life itself, often to the painful, medically drawn-out last days of debilitated patients and the inadequacy of traditional medical interventions for terminally-ill patients. He focuses on the massive expense of end-of-life care (over 25% of all medical expenses) yet patients who received medical interventions report a “substantially worse quality of life in their last week than those who received no such interventions.”

Many of these themes are relevant to the challenges that my classmates and I will face as future physicians as well as anyone who has had to confront terminal illness or the death of a loved one. Through compelling personal stories, Gawande is able to poignantly demonstrate that all parties, including patients, their families, and their health care providers, need to communicate more effectively and proactively. Some of this training is woven into our curriculum at Mount Sinai with the Art & Science of Medicine course and through third-year clerkships, but it is a process that even experienced clinicians are still working on. We cannot forget that people, not just the elderly, ultimately want to have lives of meaning, and we can inform and guide their decision-making to best accomplish this. It is up to us, as future physicians, to eschew the commonly used characterizations of illness as battles.

“Gawande is able to poignantly demonstrate that all parties, including patients, their families, and their health care providers, need to communicate more effectively and proactively.”

We must instead empathize with patients and to help them better understand how to maximize their quality of life, not just lifespan—especially through the use of the “vital questions” posed by Gawande. It may be difficult to discuss, but we need to offer hospice care as a potentially superior alternative to dying in an ICU after unsuccessful interventions and treatments. As always, it is also our responsibility as future providers to understand that topics like these affect our patients in ways we may not be able to fully comprehend.

I highly recommend reading Atul Gawande’s Being Mortal to gain some perspective on issues that are uncomfortable to think about but certainly relevant to all. It is hard to imagine a day where we can willingly accept our own mortality, but a clearer understanding of our hopes and fears may be able to better guide our decision making at a difficult time.
The Long Road to Global Consciousness [cont.]

Why did you choose to work in the field of Global Health?

Global Health for us (the Arnhold Global Health Institute) means the delivery of care for the underserved everywhere. The program started with an interest in infectious diseases and later incorporated the study of the underlying conditions of health disparities in order to deliver health to those who need it the most locally and around the world. Eventually, the program developed to be known as Global Health, and now has become an Institute as part of Mount Sinai. Here, we have programs covering domestic communities (North Dakota, Arizona) and local communities like Harlem. In order to care for those in need and reach out to more communities, we have partnered with domestic, international and government organizations.

“We also look for flexibility, humility and the willingness to learn and change as you work with these communities.”

While you were training as a resident in Pediatrics in NYC 10 years ago, you left everything you had to jump on the next flight to Sri Lanka just days after the Tsunami of 2004. Why?

Part of it was that, this is what I felt I was training for. I wanted to be of use in communities that were underserved or facing disaster. I just remember feeling a strong impulse, sense of obligation and saying to myself "I can't stay here, I have to go". I was and still am very grateful to the pediatric residency program here at Mount Sinai for being a compassionate, forward thinking and flexible institution. They helped me by freeing up my schedule and even helped me to fundraise to cover the costs of the trip. I guess, even if you are still training, be ready to answer the call when there are people who are in dire need of help.

As the Director of Education at the Arnhold Global Health Institute, what characteristics are you looking for in the current pool of students (MD’s, MPH, PhD’s) interested in Global Health training?

We are looking to see a sense of Global responsibility, including an interest in domestic populations. Individuals that own a sense of responsibility to improve conditions for everyone worldwide, that type of drive is what we look out for. It becomes evident based on their previous work experience including work as volunteers in the Peace Corps, graduates of International Development programs...some of our applicants even come with an advanced certificate in Global Health.

We also look for flexibility, humility and the willingness to learn and change as you work with these communities. We hope that these students will apply themselves to learn (new social structures, language, etc.) and that they will put the needs of the communities before their own needs.

As we send Icahn School of Medicine students to work with our partner organizations, we expect those students to take a level of excellence, ethics and integrity into the field.

What do each of these diverse groups of students bring to the Health care field?

We look for clinicians who are also educators to the local health workers. They should be able to connect with their peers and transfer their knowledge skills to improve the system at the communities they arrive. We want them to be able to bring a new perspective back to their medical practice. We hope that they will become appreciative of the differences and compare various systems of health care delivery around the world. We also hope that they become more aware of the social determinants of health such as race, ethnicity, gender, socio economic status, etc. We would like to see them bringing that understanding back to New York to serve a multicultural society. We hope that the issue of resource management will become evident and significant to them, especially after seeing health workers in rural communities functioning with very limited resources (lack of medications, sterile gloves, sterile facilities, etc.) in other part of the world. They should ask themselves, “How can we allocate resources better”?

For PhD and MPH students, we hope they will be able to translate what they are learning in the US and design sustainable ways that will be applicable in the situations they find in the field - “How can you apply your skills to these conditions”?

“The question we should be asking is, How can we enable something to happen without imposing my agenda on the way it unfolds?”

Many MPH, MD and PhD students came back this summer after studying the Community Rural Health Outreach Program (CRHP) Model in Jamkhed, India with yourself, Dr. Anjali Gupta and Renee Bischoff, MPH, MSW. Can you describe “the moment of transformation” for someone new to the field of Global Health?

There are several moments of transformation in the field. Some are personal, others professional and some spiritual. For the students who went with us to India this past year, the experience was program heightened by the fact that the living conditions were much rougher than we expected. Perhaps, many of our students asked themselves, “Am I going to manage?” This is a moment of transformation when you are confronted with a very harsh reality and find out that you can overcome this and a lot more while helping others. They got a new sense of understanding their own abilities and capacities.

Continued on the next page.
The Long Road to Global Consciousness [cont.]

It seems to me that, transformation is finding relevancy and a purpose for the work you do. The moment(s) they found something within themselves that they did not have before, and were propelled to apply their skills to improve health for all of us, as a global community.

"[There] is a moment of transformation when you are confronted with a very harsh reality and find out that you can overcome this and a lot more while helping others."

We have seen that communities empowered by training, education and self-governance have succeeded in taking care of their vulnerable populations. What are the steps to achieve that level of stability? I wouldn't call them steps as, in actuality, they are principles. To see progress will require a long-term commitment - we are talking about decades. Working in Global Health requires a balance of understanding the nature of this work and other factors such as funding cycles, politics, etc. that do not account for time. Having a long term vision and understanding that you may not see the fruit of your efforts during your commitment with the community, is essential in order to do your job well in this field and being able to enjoy it.

We find catalysts of change within the community and we prefer to move away from the “term empowerment” as it brings other connotations. The power of changing really belongs to the community itself and not to us. This is why we see ourselves as facilitators and not as agents of transferring power. It takes a catalyst in the community to spark a transformative movement and for us, is required that keep a delicate balance to do our job as facilitators of change. The balance of wanting to bring something to these communities as an outsider in contrast to offering something to a community and then being able to step back and let the community guide and drive the process on their own terms. The latter concept is really what is needed and it requires to put the needs of the community first, before our own.

Understanding the concept of ownership, and your place as a person who is facilitating the process, you don’t own that process. The process and how it evolves belongs entirely to the community as it should be, since we are confident of their capabilities. The question we should be asking is, How can we enable something to happen without imposing my agenda on the way it unfolds? We need to offer something truly skillful, yet compassionate and respectful. This is the challenge for the new generations of Global Health professionals.

Does it make a difference for women in the communities in India and Mozambique to see female doctors? Is there another level of understanding?

I think it does make a difference. There are number of female health care providers in these communities, so is not uncommon. For a girl from the rural communities we work with, becoming a doctor is more challenging. That is, to become a doctor is possible for a woman in these countries, but mostly if you come from a well educated family in an urban setting. So, the divide is not so much gender, but socioeconomic.

The number of healthy babies is very low in these communities. When training these women on how to take care of themselves and their infants, what reactions have you seen?

It really depends on the specific community and the individual women and their relationship/experience with the health system. If they have providers that they trust and respect in the system, they are more likely to listen to concepts and suggestions that may challenge beliefs and habits they already have.

For example, In Jamkhed, India they have a high level of trust, solidarity due to the 40 years this program has been involved in the community. The health care workers are local to the community who understand the culture, language and other equally important factors.

The degree of ownership and solidarity seen in the community depends on the history and the context of the community you are walking into. Also, these types of trust based relationships are long term. You can't develop these types of relationships over a couple of years.

It is truly important for there to be community based health care with an understanding of the social conditions, history and context. Hence, Jamkhed is a good example of the community driven the process to improving their own conditions.

"Make sure you are leaving in good health as you don’t want to become a burden to your colleagues and the community."

What measures have you taken to keep yourself and your staff safe in areas devastated by conflict?

Always be prepared and think ahead. Make sure you are leaving in good health as you don’t want to become a burden to your colleagues and the community. Bring personal protective equipment (mosquito nets, etc.), take all your medications with you, a complete first aid kit, have your malaria prophylaxis, get all your vaccines and don’t cut corners. You should have an insurance plan, evacuation plan, medical evacuation plan, all key contacts phone numbers and transportation arranged in case of an emergency.

Continued on the next page.
You should know the local situation, who are you allies? Who manages what? Where is the closest hospital? Make sure you register with the US Embassy. If anyone is missing in your group, make sure you follow up where that person is. If anyone is sick make sure somebody is checking on them.

Looking back on the last decade, do you have any advice for new graduates in the field of global health?

Spend much time as you can in the field. In Global Health there is nothing like field experience with a enough preparation, of course. Be ready and willing learn different skills. Ensure that you are not always working with Americans/Western organizations and challenge yourself to learn a new language and system. Get a feeling of what the real concerns of the community are, even if that means to step out of your comfort zone.

MedEd Research Corner: Practicing Resilience

How to Survive Surviving a Medical Education

Rae Dong
MS1

Last fall, barely a week into my new life as a medical student, I met an old friend from college who had recently started her residency in New York. It was still warm enough for ice cream, and we sat with our dripping cereal milk cones in Central Park, four years since we last saw each other in college. She seemed upbeat and largely caught up on sleep after finishing her “rough” rotation the previous week. “So, how’s life?” I asked generally. As the ice cream diminished we caught up on my post college work and travel, and about my decision to apply to medical school after a few detours along the way. I asked her if she had any advice, now that I sat at the beginning of one journey and she at another.

Beyond the practical tips on how to study effectively and seeking out the right mentors there was also the oft-repeated refrain to “take care of yourself” and to avoid “burning out.” I was prepared to tuck this into my back pocket along with the other warnings that med school would be hard and that self-care of great importance until she quietly mentioned that earlier that same week, a colleague in her intern class had committed suicide. She was still struggling to make sense of it. And “as much as being a doctor is the greatest job in the world, depression and burnout are real problems - problems that I’m not sure we know yet how to come to terms with.

The data on the matter is certainly less than encouraging. A review of the literature reveals that burnout is prevalent in medical students (28%–45%), residents (27%–75%, depending on specialty), as well as practicing physicians [1]. It’s worth saying that burnout is not unique to medicine. However, the challenges within medical practice and training are unique in poignancy, and worth understanding to better inform how trainees can inoculate against them.

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Defining burnout

First coined in 1974 by psychologist Herbert Freudenberger, burnout has broadly been defined as long-term exhaustion and diminished interest in work resulting from a long term exposure to stressful working environments [1]. The social psychologist Christina Maslach developed the commonly used instrument for assessing burnout, known as the Maslach Inventory, which describes the condition as composed of 3 dimensions: emotional exhaustion, characterized by lack of energy and general negative affect, cynicism or depersonalization, involving an uncaring response to others, and reduced personal accomplishment, whereby individuals believe they will not be able to do their jobs adequately[2].

Burnout has been defined in the World Health Organization’s ICD10 (International Classification of Diseases) as a “state of vital exhaustion.” Although burnout is not recognized as a distinct disorder in the DSM5, it has been shown to be associated with depression and even increased rates of cardiovascular disease and inflammatory biomarkers [3].

Burnout in medical school

Medical school is a notoriously challenging experience during which students undergo tremendous personal change and professional growth. Though the stressors that come along with this are varied and unique to each student’s context and experience, they may be categorized within a few common themes. Harvard psychiatrist Raymond Laurie has previously described the concept of “role strain” with respect to negotiating relationships with their families, friends, partners, peers, attending physicians and patients. Additionally, with regard to students’ concept of themselves, individuals who have high achievement may be challenged in new ways both intellectually and emotionally.

Stress levels are known to be particularly high in the third year, as students make the transition from classrooms to clinical wards. Continued on the next page.
Dean Charney didn’t originally set out to study resilience in medical students. In fact, in the late 1980s as a neuroscience researcher at Yale, he first became interested in studying PTSD in veterans after he and colleague Steve Southwick noticed that PTSD did not strike veterans indiscriminately. “We decided that there was a lot we could learn about people who were traumatized, but didn’t develop PTSD. In other words, people who were resilient.”

As is described by Dr. Charney and Southwick, materials and objects are termed resilient within the physical sciences if they resume their original shape upon being bent or stretched. In people, resilience refers to the ability to “bounce back” or “bending but not breaking” after encountering stress or trauma, sometimes even growing from the experience [6]. Charney and Southwick’s work has since explored the biology of stress and its impact on the brain through the study of groups who have faced uniquely challenging circumstances (ranging from navy SEALs and former Vietnam POWs to individuals born with congenital diseases), to determine whether there were traits that were protective against PTSD, or predictive of resilience.

Over two decades of research, the traits that were found in individuals who seemed able to “bounce back” even after facing significant trauma converged around a number of common themes. (Figure 1)

To take one example, the importance of role models is of particular relevance for medical students because of the apprenticeship model in which training programs are structured. The results from the 2009 study showed that support from team members was instrumental to increasing levels of personal growth following exposure to trauma. At the same time, the study also echoed previous findings that poor role modeling by superior physicians correlates with increased student cynicism as well as rates of anxiety and depression [5]. As such, these results emphasize the importance of positive faculty-student dynamics to facilitate a supportive training environment.

Notably, this framework suggests that resilience is more than a concept and is in fact an approach to living. It submits that these traits are not fixed in our personalities but changeable, with the possibility for improvement, but that it likely won’t be easy. Building resilience requires practice and consistent effort over a sustained period of time. Rather than trying to implement all ten strategies at once, Dr. Charney suggests choosing one or two ideas that feel natural and seem doable [6].

“…[a 2009 Mount Sinai led] study notably found that students who encountered more traumatic events also experienced more personal growth, suggestive of resilience.”

In her 2004 memoir The Year of Magical Thinking, Joan Didion reflects on growing up the daughter of a geologist. “A hill is a transitional accommodation to stress and ego may be a similar accommodation. A waterfall is a self-correcting maladjustment of a stream to structure and so, for all I know, is technique.” Ultimately, we all need to discover the strategies that best address our own structural stresses and maladjustments – whether it be reflecting upon difficult situations with trusted mentors, friends, or family, or utilizing the various resources available at Icahn school of medicine, ranging from student mental health to student led organizations (Appendix 1). As medical students it is upon all of us to proactively pursue our best selves. Indeed, our future patients will be counting on it.

**The Resilience Prescription**

**Physician:** Dr. Dennis Charney  
**Refills:** Unlimited  
**Patient:** You

1. Positive Attitude  
2. Cognitive Flexibility Through Cognitive Reappraisal  
3. Embrace a Personal Moral Compass  
4. Find a Resilient Role Model  
5. Face Your Fears  
6. Develop Active Coping Skills  
7. Establish and Nurture a Supportive Social Network  
8. Attend to Physical Well-Being  

**General Principles**

9. Train Regularly and Rigorously in Multiple Areas  
10. Recognize, Utilize and Foster Signature Strengths

*Figure 1. The Resilience Prescription*

The medicine that is taught is no longer in abstract or in theory, and the consequences of the care given are directly observable in the lives of patients. As such, the clinical experiences that students encounter may at times be tremendously rewarding, but also challenging when patients’ conditions decline or when they eventually pass away [4].

In a 2009 study of Icahn School of Medicine’s third year medical students, a research team led by Haglund, Dr. Charney and Southwick assessed the impact of trauma (as stipulated by the criteria defined in the DSM-V) on medical student well-being. While the study confirmed that trauma exposure is indeed common at this juncture in training, the study notably found that students who encountered more traumatic events also experienced more personal growth, suggestive of resilience [5].

What is resilience and how can it help us?
MedEd Research Corner: Practicing Resilience [cont.]

Dr. Charney will be giving a lecture on the topic of resilience in medical trainees, sponsored by the Icahn School of Medicine Wellness Committee on April 7th from 5-6:30PM in Hatch Auditorium.

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<td>Face your fears</td>
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Appendix 1. Selected Resources for Traits