Remember: Don't Plagiarize!

Annie Apple – Final Draft *(Emergency Medicine)*

I was sitting with my back up against a tennis court fence and crying on the phone with my pops. It was the best place I could find while coaching a nordic junior race in Sun Valley, ID. Months of bottled-up disappointment, confusion, and lack of motivation came spewing out. I crouched there and sobbed: It was half a year after graduating with my Master's in Bioengineering, and I was still coaching and working in retail, because I did not actually like the career for which I had studied so hard. I was afraid of being stuck in an office cubicle, staring at a computer screen, writing code, and generating medical models. I had slowly realized that this path was not enough; I wanted to be able to build relationships and solve problems meaningful to me.

Painful as this was, this realization was the first step of my trek into medicine. I put my pride aside and began the slow process of making a dramatic career change. I started by pushing patients in gurneys around a hospital for minimum wage, so that I could get my foot in the patient care door. Slowly chipping away at medical school prerequisites, I became an Emergency Department (ED) tech. While observing the many complex layers of medicine, I evolved into an integral member of the healthcare team. I loved the crazy and gratifying moments of my new job -- laughing over a hard-earned toe IV or comforting a patient while gently placing a splint to help ease pain. Though only the beginning of my long path toward a career in medicine, I knew I had finally found the right direction.

While I loved working in the ED as a tech, once I started medical school, I kept an open mind about what career path I might want to explore. Progressing through my clinical rotations, I discovered the experiences that made me the happiest. I liked the feeling of staying calm during stressful situations, like resuscitations or trauma activations, and I found I did not want to be pigeon-holed into studying one organ system. I wanted to be there for the strokes, the babies with fevers, and the elderly with broken hips. Through my work with "Here to Help," and my research on adverse childhood experiences, my eyes were opened to the underserved patient population of the ED and the complex struggles they face. I realized the significant impact life experiences have on shaping behaviors and I gained compassion for the heartbreaking decisions that are often made. Growing up in a rural community, I was surrounded by a different kind of disadvantaged group. I understand these rugged folks. I appreciate their quirks, their stoic demeanor, and their pride. I want to be a trusted healthcare resource for them as we joke about the snow in May, the best fishing spot, or our voracious black flies.

In addition to loving the diverse patient base, I thrived on the teamwork that is necessary for the ED. I found my hospital's Emergency Medicine leadership group to be both inspirational and staffed with strong, decisive women, with characteristics to which I aspire. The collegial team members of nurses, techs and doctors reminded me fondly of my nordic ski racing team in college, where we all worked hard together, supporting one another, and pushing each other to continued success. I enjoyed the patient-care autonomy I experienced in the Emergency Department and felt comforted in knowing that I will be supported by an experienced and diverse ED team, with much wisdom to share.

As I complete medical school and embark on a career in Emergency Medicine, I think back to the day when I was sitting by the tennis court trying to inconspicuously sob, out of view of curious high schoolers. I cannot help but recognize the stark contrast between the emotions I felt after graduating from my master's program and those I experience as I finish medical school. I am proud and motivated, with a clear sense of purpose as I prepare to become a competent, focused, empathetic Emergency Physician.

Barbara Barker *(Emergency Medicine)*

New Mexico has shaped me, the way the river shaped the Rio Grande Gorge. I was raised in Taos, a rural town in northern New Mexico. Taos is a place of contrast and intersection: of mountains and desert, vibrant traditions, diverse culture, of devotion to land and family. The richness of outdoor beauty is juxtaposed with a stark reality of poverty, gang violence, and substance abuse. For me, these contrasts converged, inspiring a career in emergency medicine.

The wilderness has been an instrumental teacher in my life. While rock climbing with my dad in middle school, he fell thirty feet to the ground and broke his back. I remember hanging in the air utterly helpless, not knowing what I could do as I screamed for help. Ever since that moment, I have strived to overcome these feelings of helplessness and futility at the scene of an accident—to transcend them through action.

My love of the outdoors and desire to help people drew me to wilderness and emergency medicine. In college, I joined the Dartmouth Ski Patrol and took a Wilderness-EMT course, immersing myself in a community passionate about medicine and skiing. In wilderness emergency care, I had to improvise, think on my feet, and stretch my imagination using just the contents of my backpack. I found myself empowered, learning the tools of patient assessment to stabilize and care for life-threatening injuries. No longer frozen at the scene of an accident, I felt my helplessness melt away into smooth action.

While skiing during my clerkship year, I heard a call for help in the lift-line. A man, very much alive moments previously, was unresponsive with no pulse. Despite my limited training, I took a deep breath, trusted myself, and started chest compressions. Ski patrol arrived and began running the code like a well-oiled machine. I stepped aside to talk with his distraught friend, put a warm hand on his shoulder for support, and elicited vital history for the team. I tried to intuit how to help: moving gear out of the way, problem-solving when oxygen hosing did not fit, and rotating in for compressions. In what felt like both an eternity and yet an instant, we delivered two shocks and there was a return of circulation. Months later, we received a letter from him saying that he had made a full recovery and would be back skiing next season.

I have always been drawn to emergency medicine, and after that day it profoundly settled on me—this was what I want to do. Part of it was the need to think on my feet, the profundity of performing CPR, and the problem-solving to help bring about a truly miraculous save. But it was more working with a team, appreciative of our clear communication and trust in our strong protocols. It was being there for his friend during those moments of crisis.

I want to be available—there to help whoever is in front of me. I want to have the skills to stabilize a patient with a stab wound, to advise the new mother late at night with nowhere else to go, or to address an overdose in a rapidly deteriorating patient. There is a depth to each patient's story. The contrasts and crises that I witnessed growing up in New Mexico exist in emergencies departments across the country. I hope to be more impactful: to connect my patients to lifelines of resources, to help them leave with hope and means to actualize real change in their environments. These moments of crises, intensely intimate, are the beginnings of healing. So

often this journey begins in the emergency department, where we have not just the responsibility, but the privilege, to start it with our patients.

Cathy Cook draft 2 *(ObGyn)*

An early lesson in public health is that medical care itself is only responsible for about 15% of modifiable determinants of health in the US population. I have always found that number surprisingly low as someone who wants to practice clinical medicine.

It was not far into graduate school that I realized there is a compelling cross section of public health and medicine that works to expand the reach of that 15%. There, I was exposed to doctors with dual training in medicine and public health. They spent clinic days seeing patients and office days overseeing disease control programs and research efforts. It was the answer to the question I had, but had not figured out how to ask yet: how can one inhabit a space to directly counteract health care inequity by seeing, hearing and caring for patients, yet still have influence over the higher structural forces that make old, baked-in problems difficult for one person to face?

It is with a career in OBGYN that I hope to build my own niche in this cross section of public health and medicine. It is a specialty that inspires me to take on the endeavor. OBGYN has special ties to primary care and an important role in providing access to improve health disparities across gender, race and socioeconomic status. This was the salient point of the most transformative class I took in graduate school: international maternal and child health. Most maternal deaths globally are preventable, and often with just basic antibiotics, oxytocic drugs and placental care. Contraception is “low-hanging fruit” to combat maternal mortality by preventing unwanted pregnancies, an intervention that is also fraught with access obstacles. Infant mortality, and even global rates of mortality under five years of age, is intimately linked with health of mothers and circumstances of delivery. In many ways, healthier moms are the way to a healthier world.

In addition to the unique link between OBGYN and public health, I am drawn to its breadth and its pace. I love the high intensity teamwork required in the OR and the anticipative air of the labor and delivery floor. And it is a fascinating human feat when these two come “crashing” together; it requires swift decision-making, high-functioning collaboration, and a certain mix of force and finesse. I have always reveled in being a part of a great team, whether it was my national championship ultimate frisbee team in college or a group of seven second-year medical students, taking on the analysis of thousands of responses to a university-wide survey on e-cigarette use. This mindset will serve me well on a resident team, where I will be able to quickly integrate into my role while keeping a keen eye towards lessons, wisdom and skills to be learned from colleagues and mentors. I have always respected the path toward excelling through patience and repetition.

Clinical excellence is the next step to build my career in public health and medicine. I view residency as the single most important piece of the trajectory towards my career, and my professional background in public health supports a deep appreciation for the broader structural context in which I will train. I have big dreams to care for patients and touch individual lives while overseeing maternal and child health programs at the local government level. I want to do work that will stretch that 15% to those who need it most. I am a hard worker, a great team player, and have a commitment to OBGYN grounded in long-term goals to be an excellent clinician and public health expert for my community.

Daniel Day Lewis *(Emergency Medicine)*

As a regenerative biology researcher in college, I was captivated by the seemingly limitless therapeutic potential of undifferentiated, pluripotent stem cells. Now, as I enter the final stages of medical school, I realize that it is the undifferentiated patient who excites me most. I love reasoning through the most likely, can't miss, and uncommon explanations of a patient's chief complaint, refining my list as I gather new evidence. Developing logical diagnostic and treatment plans, after beginning with little information, is what first piqued my interest in Emergency Medicine. Having spent the last few months in a variety of diverse Emergency Departments, my passion for the specialty has only grown, as I recognize that it is built on a foundation of teamwork, empathy, and justice – values which have long been important to me.

When a young woman was brought in following a motorcycle accident, I was tasked with completing the primary survey. When I had the opportunity to step back and look around, I was struck by the solidarity that existed among the members of my team. Each of us had a role, but together we took swift, calculated actions that ultimately saved our patient's life. I thrive on high-functioning teams and seek leadership opportunities. As chair of the New England Emergency Medicine Medical Student Council, I organized educational, community service, and advocacy events, all while grappling with the realities of a new pandemic. I want to continue growing as a leader, and strive to be someone who can be trusted even in the most demanding circumstances, in a field where respect, effective communication, and unity among team members is essential.

When a 4-year-old girl with fever in the setting of relapsed ALL began to cry, I helped her place farm animal stickers in a book so we could collect blood from her chest port. I take pride in my ability to build trust and empathize with patients in stressful, time-sensitive situations, and want to take on the remarkable responsibility of being the first, and oftentimes, only, physician a patient will see during a particularly vulnerable time. I have learned that patients expect efficient, quality care from their visits to the Emergency Department, but what they appreciate most is feeling valued and heard. In an environment that can be anything but soothing, I want my patients to leave knowing that they have a safe, welcoming place to return should they experience another health emergency.

When a man arrived from a nearby maximum-security state prison, I learned his name, the characteristics of his chest pain, and that his ECG showed a STEMI. I did not know why he laid there clad in a forest green jumpsuit, his legs still shackled to one another. Those circumstances were irrelevant, because of the ubiquitous concept within Emergency Medicine that we will evaluate and stabilize everyone who presents to the department. Justice is important to me, and I have found ways to make small impacts, like teaching children in underserved schools, vaccinating migrant farmworkers across my home state, and working on a gubernatorial campaign that championed a more equitable delivery of healthcare. As someone whose lived experience has been shaped by privilege, and with healthcare becoming increasingly inaccessible for many, I am motivated to enter a field that takes pride in caring for all.

I want to become an Emergency Medicine physician at a residency program that shares these values of teamwork, empathy, and justice. I hope to serve a diverse population in a fast-paced,

high-acuity setting, while equipping myself with the cerebral and manual skills I will utilize to serve patients for decades. I want to continue being active in research, understanding the importance of evidence-based medicine and refusing to grow complacent in our current standards of care. I love to teach, and hope that my residency training will one day lead me to an academic or large county hospital where I can continue serving patients, while contributing to the growth of the next generation of Emergency Physicians.

Edward Edwards *(Internal Medicine)*

There is a bicycle hanging in my garage—a deep grey with red grip-tape, and "Trek" painted on the frame in maroon lettering. Built in 1987, the bicycle shows the wear and tear from a lifetime of love and frequent use. I inherited the Trek from my dad long ago, and in the ensuing years the bike carried me to work, provided opportunities to refine my repair skills, and accompanied me on many adventures.

Several years ago, one of the brake cables on the Trek began to fray. I had never replaced brake lines before, but I researched replacement parts, made a purchase, and puzzled through the process of installing new cables. I made mistakes, but came away with grease-covered hands, a new skill, and an improved bicycle. As someone who enjoys understanding how things work, I find my interests in bike mechanics are akin to my curiosities of human physiology and how it can go awry. I entered medical school with a degree in Biology, experience with clinical research, and an enthusiasm to learn how biological concepts and research findings translate into patient care.

Not only did medical school provide a wealth of information to satisfy my curiosities, but also allowed me to discover a passion for listening to patient stories. During my clinical years, I recall watching an Infectious Disease physician use thoughtful questions to uncover several co-morbid diagnoses in a young man with an untreated HIV infection, amazed how the doctor was able to piece together clues from the patient's story to guide a thorough workup and get the patient the care they required. I worked to improve my own patient interactions by incorporating the strong listening skills and attentive history-taking I observed. I also learned to use the scientific literature as a tool to guide treatment decisions, a skill refined by the opportunity to consult the literature on COVID-19 during the early stages of the pandemic in an effort to answer questions from providers about the virus. In addition, medical school helped me realize my love for sharing what I learn with others, both in the clinical setting with patients and while educating colleagues about the results of a research study.

Above all, my experiences reaffirmed that personal connections established during patient care can be remarkably meaningful. During an Internal Medicine rotation, I cared for a man with transaminitis. He seemed anxious. After taking time to listen to his concerns, I realized he was afraid he was experiencing acute liver failure because no one took the time to explain what his lab results meant. I reassured him—an easy intervention that provided relief and understanding. This experience reinforced for me how simple acts, such as patient education, can play a significant role in the therapeutic process.

I chose to pursue Internal Medicine for its diagnostic puzzles, foundation in scientific knowledge, and the opportunities to build compassionate relationships with patients. I am looking for a residency program focused on providing excellent clinical training. I loved learning

from teaching attendings during medical school, and I appreciate a training environment that prioritizes resident education and offers experiences working with students. I envision incorporating research into my career, and my ideal program would encourage research and faculty mentoring. Most of all, I hope to find a program with a supportive community that values compassionate, patient-centered care.

Fiona Fields *(Psychiatry)*

Eighteen years ago, my younger brother D was diagnosed with autism spectrum disorder (ASD). He lacks communication abilities, struggles with bowel and urinary continence, and engages in nearly continuous self-injurious behaviors. Life for my family was changed forever. As a family, we try our best to deduce his needs nonverbally, but remain on constant alert for his safety and needs. Almost two decades of observing and participating in his care have taught me about perseverance, sacrifice, and patience. Growing up with D has been a cherished experience that has allowed me to appreciate the challenges and joys a family can encounter in raising a child with special needs. I have had the unique privilege of serving multiple roles in the care of a complex patient – as a family member, a respite provider, a language and cultural translator, and an advocate. My broad involvement in the team led to my decision to pursue medical school because I witnessed the large impact D's physicians had on his care.

Taking care of D accelerated my development of empathy and compassion for the feelings and behaviors of individuals with psychiatric disorders. In recent years, D has developed severe symptoms of obsessive-compulsive disorder. He compulsively hides his belongings under the furniture, uncrosses everyone's arms or legs, and closes every open door. These compulsions have not improved with the treatments available to our family, causing enormous difficulties for us all. At first, this tested my patience, but as I realized that neither he nor I could change these behaviors, I gradually began to accept them. First-hand experience dealing with his existing and emerging needs has continuously inspired me to seek their medical causes and solutions, which in turn increased my curiosity and interest in the field of psychiatry.

Understanding an individual from a holistic perspective, considering both the mind and the body, appears to me as a physician in training, to be incredibly important to providing the best care possible. I believe psychiatry best lends itself to this approach. During a rotation at a high acuity state psychiatric facility, I cared for Mr. G, a middle-aged refugee with severe posttraumatic stress disorder. He was court-ordered for involuntary admission due to his first acute psychotic episode resulting in an alleged crime. We were able to connect as human beings, and I had the opportunity to learn about his internal vulnerabilities and fears—from his experience of psychosis to his time at a refugee camp. Based on an increased understanding of his psyche, I was able to individualize my approach to support him. His limited English skills prevented him from fully participating in his own care, which I could relate to from my background as someone who grew up in an immigrant family with a brother who has a complex psychiatric disorder. My clinical experience confirmed my decision to pursue psychiatry as I felt fulfilled when I was able to use my background and skillset in a meaningful way.

Within psychiatry, I hope to work with underserved populations, such as those with neurodevelopmental disorders, refugees and immigrants, and individuals with other minority statuses. I have witnessed how resource availability and socioeconomic barriers affect these groups, increasing my drive to advocate for them to have equal access to high-quality medical care. I look forward to finding peers and mentors with similar interests to develop the breadth of skills necessary to provide effective patient-centered psychiatric care in minority groups. Additionally, I hope to lead an initiative to decrease stigmatization for psychiatric disorders in local communities through culturally appropriate education to minimize misconceptions and increase trust to seek necessary psychiatric services. The extraordinary lack of resources in psychiatry as seen in Mr. G's case furthered my desire to improve overall access to and quantity

of psychiatric resources. This critical shortage motivates me to contribute to the field of psychiatry by advocating for improved services and providing personalized and compassionate care to those individuals and families most in need.

James Johnson *(Orthopedics)*

When I was nine years old, I spent three weeks essentially living at Boston Children's Hospital while my little brother had his life saved by the pulmonary team there. From then on all I ever wanted was to be a doctor, but I was raised a world away in the working class. A chef by trade, my father fulfilled his dream of opening his own restaurant after years of working three jobs and borrowing beyond his means. I was put to work right away, earning my first paycheck at twelve years old; starting in the dish pit and slowly working my way up the "back of the house" ladder. It was grueling work, but I soon came to appreciate the efforts required to excel. I saw the talent of the cooks and chefs around me and for the first time outside of athletics I began to train my body to develop a skill set, a trade. I was taught to care for my knives, to dice and julienne, that to work slowly is to be precise and to be precise is to be fast, and most importantly how to truly work *hard*. I have seen my whole life the value of possessing hard earned mastery and I wanted that for myself. By the time my father's restaurant went bankrupt during the recession in 2009 I was third in command on the kitchen line and sixteen years old.

I was never going to be a chef, but I loved working with my hands and learning new ways to do so. I became a butcher in college, learning a new skill set and loving the anatomy and dissection aspects of the job. I can still break down a chicken in a few minutes. I also moved to the "front of the house", becoming a bartender at a fancy cocktail bar. These skills are what kept me above water during college and after when I was cutting my teeth as researcher, working days in that lab to get into medical school and nights at the bar to make rent. I had spent eighteen months working on my undergraduate thesis in biochemistry on the mechanism of an anti-malarial drug target, ultimately publishing my work as first author in *Biochemistry.* When I began working at Bigham and Women's after graduating, I was lucky enough to find a small genetics lab that let me design and carry out my own experiments using cutting edge techniques such as CRISPR; a dream job for a researcher without a graduate degree. It still was not enough, I liked people too much and mice not enough to continue that work long term. When I was able to transition to clinical orthopaedics research in ankle biometrics and arthroplasty during medical school, I saw a future in which I could continue to pursue research throughout my career.

It was also during medical school that I realized my years spent cooking were not wasted time. I wanted to be a doctor, but I realized about myself that I also need to learn a trade and work with my hands, that I must become a surgeon. I saw surgeons working long hours on their feet, diving into their work with the precision, speed, and skill I had not felt since leaving the kitchen line. The environment was oddly reminiscent, alternating between relaxed jovial needling of those less experienced and high stress moments of sudden exclamation or silence. I couldn't get enough, spending my first two years in medical school shadowing in the OR as much as possible, gaining exposure to the full breadth of the surgical fields but continually finding myself back in the same rooms. After seeing my first knee replacement and poly-trauma I found it hard to spend time anywhere but orthopaedics.

There are many things that drew me towards orthopaedic surgery; its complex but solvable problems, my love of anatomy, and treating patients that often fully recover and heal. However, what led me down this path and what continues to drive me is that more than any other surgical field orthopaedics feels so much like where I come from, like home. I chose orthopaedics because I want to face problems with definite and fixable solutions, to strive towards mastery, to form lasting relationships with patients, and to base it all on a strong background of research and evidence. I truly believe that I bring with me the work ethic, motivation, and attitude to become a great orthopaedic surgeon.

Leslie Lockhart *(Plastic Surgery)*

The first time I attempted to make French macarons, I assembled a gorgeous sheet of perfectly round and entirely inedible cookies. This was not altogether surprising because anyone who knows their way around the kitchen will tell you that anyone can *cook*, but baking is *science*. When the macaron recipe calls for 90 grams of flour, that precision is required: one leveled measuring cup will not suffice. Of course, there is artistry and creativity in the addition of pastel hues and flavored extracts, but pretty macarons that are also delicious cookies require a level of attention to detail that felt familiar when I began my surgical rotations.

Anatomy is the surgeon's ingredient list, and like the macaron recipe, substitutions or shortcuts will lead to disaster. Also, technique matters. How a surgeon chooses the ideal incision angles, depth, and even suture size fascinates me. How a resident learns these skills to a point that they seem innate requires rapt attention and lots of repetition. And like all skills, it takes more doing than watching to achieve anything close to talent.

The first time I came even close to the operating theater, I was on a mission trip with my parents. Dad is a hand surgeon and devotes a few weeks a year to spending time in the Dominican Republic, and on this trip he promised I could assist. My first assignment was menial. As I was tending to patients in the holding area, dad made me carry around a needle driver. Open, close. Open, close.

"If you can't do that quickly with one hand, you don't belong in my OR."

Eventually, I was allowed inside to "hold hook". Later, I swiped some sutures, pick-ups, and chicken wings and started practicing. I wanted to belong in the OR.

Finally, my surgical rotation began, and I felt something akin to confidence walking into the OR. Open, close. Open, close. Stay out of the field. Retract well. Be helpful. Know the anatomy. One of the first cases was a traumatic hand injury. Nothing was normal, her anatomy was distorted and destroyed. There are no books to explain how to reassemble a hand that has been thrashed by a meat grinder. However, I was able to fall back on a rudimentary knowledge of the anatomy of the hand, however distorted it had become, and marveled at the ability of this surgical team to restore function and form. I went from holding hook to being hooked.

Today I will tell you that the kitchen and the operating room are places I feel the most useful and content. Never shy to share and usually chatty, in the OR I am quieter and prefer to listen. In the kitchen, I have learned from mistakes that have very low stakes. On the surgical team, I am relieved that problem solving is a group effort that ensures we "first, do no harm" because I have so much to learn. Inevitably, when I am asked where I see myself in 5 or 10 years, it is the operating room I envision. Only now, I know most of the recipes by heart.