

The Hopkins Med LIVEWell Newsletter

Welcome to the first ever issue of The Hopkins Med **LIVEWell** Newsletter! We hope to build a tradition of wellness at Johns Hopkins, and this publication attempts to capture the energy and enthusiasm of students so that we can all collaborate to change the wellness culture as part of our professional developmental responsibility to care for ourselves so that we can care for others.

In this issue, you will find information about student-planned wellness activities, news and notes about the latest happenings on campus and in the community, as well as publications by your colleagues—all intended to help students express what wellness means to them individually. We thank you for taking time to read through this issue, and we invite you to participate actively in the future by sharing with us about your wellness activities and events and by submitting written and artistic pieces to publish—this is a standing invitation to submit expressions of all types!

Finally, if you'd like to communicate about wellness on a regular basis with your colleagues, please join the LiveWell listserv as a tool for posting questions, sharing articles, and facilitating conversations about wellness topics: <https://lists.johnshopkins.edu/sympa/info/livewell>

1. LIVE WELL CALENDAR:

- Wellness activities and events for Hopkins Med students! See “Notes” for details.
- Please send planned activities and events for July to HopkinsLiveWell@gmail.com.

~ June 2014 ~						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
15 10:30 – 12 = Dance 12:00 – 2 = Basketball 4:30 – 5:30 = Yoga	16	17	18	19	20	21
22 10:30 – 12 = Dance 12:00 – 2 = Basketball 4:30 – 5:30 = Yoga	23	24	25	26	27	28
29 10:30 – 12 = Dance 12:00 – 2 = Basketball 4:30 – 5:30 = Yoga	30	Notes: → Yoga organized by Rhianon Liu (rliu7@jhmi.edu); held in Cooley Exercise Studio. → Dance organized by Arielle Medford (amedfor2@jhmi.edu); Cooley Exercise Studio. → Basketball organized by Brent Pottenger (bpotten1@jhmi.edu); Cooley Gym. → All of these activities are free and open to students of all experience-levels—JOIN!!!				

2. ROUNDING THE DOME:

- News and notes from around The Hopkins Med campus!



On May 22nd, 2014, Hopkins said goodbye to yet another wonderful class of students at the Commencement Ceremony. As bittersweet as it is to see these individuals go, we watch them leave with great admiration and respect as they have now completed their medical school journeys. However, it is not completely goodbye to the entire graduating class—approximately one-third of the class will be training at Hopkins for some duration during their residency. And now, when we see them in the hospital, we no longer look at them as our colleagues, but as our educators. We wish the students of Med14 the best of luck in their future endeavors and express our utmost confidence that they will all go on to have tremendously successful careers as physicians, scientists, and healthcare leaders.

3. BE MORE PART OF BMORE:

- Information about community events and happenings in Baltimore!
 - o *Mount Vernon Place Conservatory*: <http://mvpconservancy.org>
 - Free yoga classes on Saturday mornings at 8:30 AM in East Mount Vernon Place Square.
 - Free outdoor concerts on Wednesdays and other interesting cultural events (please see calendar on Web site for more information).
 - o *BMore Interested*: <http://www.bmoreinterested.com/2014/04/baltimore-outdoor-movies-2014.html>
 - Free outdoor movies (please see calendar on Web site for details).
 - o *2014 Baltimore Pride Parade and Festival*: <http://baltimorepride.org>
 - June 14th and 15th in Mount Vernon area (please see Web site for details).
 - o *Beginner Swing Dance Lessons*: hopkinsdance@gmail.com

- Thursdays, July 10th, 17th, and 24th, 7-8 PM in Daily Grind Café, located on 3rd Floor of Ross Research Building.
- FREE for all medical and graduate students (with valid JHU ID Card); and, \$5 per lesson for all others (staff, faculty, post-docs, non-Hopkins, etc.). No experience or partner required! Everyone is welcome! You will be required to show identification to the security guard and sign in when entering the building.

4. PHYSICAL HEALTH SURVEY:

- Student Wellness Initiative (SWI) survey about student wellness needs and priorities, specifically about nutrition and physical activity!
 - Please complete the following survey by June 30th:

→ *CLICK HERE:*

https://docs.google.com/forms/d/1uOntdIB2TfLABK9N6Tcw6sR4cVBfIbjHXIL7alV-6HY/viewform?usp=send_form

5. EXPRESSING WELLNESS:

- Student publications of all types to express personal wellness!
 - Please submit poems, essays, reflections, drawings/art, photos, and other creative pieces to HopkinsLiveWell@gmail.com by July 20th for the July Newsletter.

“Can’t or won’t”

By Brent C. Pottenger, MHA, MSIV (**Taussig** College!)

NOTE: In the following story, names and details have been changed or made generic to protect peoples’ identities and privacy.

“Can’t or won’t? That’s the question,” the attending psychiatrist asked me.

“Can’t,” I responded.

“Won’t,” he replied.

It was 10 AM. We had just finished morning rounds. It was my first week as a medical student on the team. The previous day, I admitted Patient VA to our service. VA was transferred to us from another hospital for treatment of his refractory, disabling chronic pain and depressed mood.

VA grew up with a genuine drive to serve. He loved America and public service. When he finished high school, he joined the military: “Those first few years were the best of my life,” VA commented about the start to his public service career. Everything changed, however, with a simple misstep during morning drill activities: he took one awkward turn while performing a routine drill, lost his balance, and “pop”—he could not bear weight on one of his legs. He was out of commission temporarily. The military officers thought differently, though. After an x-ray in the Emergency Department failed to show evidence of a fracture, the officers were convinced

that the injury was a simple sprain; they expected VA to be back in action, participating in drills again within a few days.

“They were really abusive to me. I went back to training a few days later, but I couldn’t do it. My leg was swollen and was black and blue—I was in excruciating pain,” VA shared with me. “When I told the officers that I needed to rest my leg to let it heal, they responded by calling me names: they called me a ‘lazy piece of s_____’ and other disrespectful things,” VA added, recalling the mistreatment in frustration. After this game played out for about a month, the officers finally relented to the idea that this injury could be more serious than a simple sprain when they noticed that the swelling and the discoloration in VA’s leg worsened with each passing day. VA was sent to see an orthopaedic surgeon who ordered an MRI; the findings were revealing: in fact, VA had torn ligaments in his leg—it was a severe injury, a surgical case.

Soon thereafter, the orthopaedic surgeon took VA to the operating room. The saying “lightning never strikes twice in the same place” proved untrue for VA, unfortunately: during the operation, the surgeon nicked nerves in VA’s leg in error. “After the operation, my leg hurt even more; the swelling increased, and I felt sharp, shooting pain up and down my leg constantly,” VA recalled. “It was like my leg was on fire.”

And the snowball gained momentum.

In the weeks following the operation, weakness and pain took VA’s leg hostage, limiting his mobility significantly. After attempts with bracing—but no physical therapy—the orthopaedic surgeon made the ever-so-tempting decision to divorce himself from the case—transferring responsibility from himself to the patient, shirking responsibility for the adding-insult-to-injury mistake that he made in the operating room: “This is psychiatric pain,” he said, telling VA that his pain was “all in his head,” despite the glaring, concrete physical reality that his leg was swollen from toe to hip, colored as if it were attending a funeral.

The next two years unveiled a funeral of sorts for VA. Doctors prescribed increasing doses of opioids and other analgesics to block his pain, setting off a feedback cycle that fueled hyperalgesia: an increased perception of pain. The more pain medications he took, the more pain he experienced. And then he fell: his leg gave out one afternoon; his leg could no longer bear his weight due to pain, nerve injury, and swelling. Unable to walk, he had to use a wheelchair to move about as he waited for the doctors’ next moves. Immobility only worsened function, though: his injured leg became weaker and weaker from disuse atrophy. Soon, he could hardly move the leg. His doctor referred him to a neurosurgeon who assessed the situation and opted to implant a nerve stimulator in his leg, hypothesizing that augmented neural signals transmitted to the muscles in the leg would help VA regain the ability to move it enough to ambulate. But lightning struck again: the operation succeeded in stimulating some movement in his leg, but a post-operative infection at the surgical site where the stimulator device was implanted in VA’s thigh caused another painful experience. Within a few months, the nerve stimulator stopped working, and VA’s mood and outlook on life were plummeting.

When you have a hammer, everything looks like a nail.

Soon, sitting in a wheelchair around-the-clock, his body flooded with analgesic medications, VA noticed that his other leg became less responsive to his conscious input: as occurred in his injured leg, disuse atrophy eroded function in his other leg. The neurosurgeon recommended another nerve stimulator implantation procedure. This time, the surgeon implanted the device in VA's back to stimulate his spinal cord and send enhanced neural signals out bilaterally to both of his legs. Again, the device succeeded transiently, but within a few months, after not being able to free himself from the wheelchair despite the nerve stimulator's assistance, VA was completely immobile, unable to move his legs against gravity.

He was diagnosed with Complex Regional Pain Syndrome, a condition that occurs when trauma to one body part, such as damage to peripheral nerves, leads to a chronic, often debilitating pain experience that spreads from the local injury site to other regions of the body. For VA, he experienced diffuse pain from his lower back down, in the entirety of both of his legs.

He became suicidal. He lost hope. He was in constant pain and felt like nothing was working to free him from this snowballing trap of immobility and loss of function: *of loss of self*.

Willing to do anything that might help, he saw a pain specialist in another state. This physician opted for an epidural catheter for more potent pain control. But this was just another "pain blocker" approach to management—palliation—it would at best dampen some of VA's pain experiences. More likely, it would worsen his hyperalgesia.

And it did.

"The pain was so bad, I just gave up. I sat in my room all day; I wanted to end my life," VA shared with me, in tears. VA heard about a treatment for Complex Regional Pain Syndrome called a "ketamine coma," and it peaked his interest. Ketamine is a drug used for anesthesia, and some pain specialists have recently used it as a chronic pain treatment: patients are given ketamine in dosages that cause them to go into a comatose state for seven days. When they wake up, their pain improves, according to advocates. On its face, this is quite a drastic approach to managing pain. But people in pain get desperate, and they are willing to try anything.

Luckily for VA, his suicidal ideations resulted in a psychiatric hospital admission. And he did not pass the neuropsychiatry evaluation required for ketamine coma treatment. During this admission, he was transferred to our service for care.

"You'll walk again," the attending psychiatrist told VA on the second day of his stay.

Back to 10 AM.

"Can't or won't?" the attending asked me again.

"Can't," I answered, standing my ground.

"Nope; it's won't," the attending replied.

The attending was referring to VA's ability to walk. The attending suspected that VA was capable of walking; that he was staying in his wheelchair and was not moving his legs in order to achieve a secondary gain. The attending also suspected that VA was walking secretly; that when we were not looking, he walked—that VA was, at some level, “faking” his immobility.

“I think it's similar to when people do not work out for a long time. When they go back to the gym, they cannot do the same activities that they used to do. The initial gains in strength from working out again come from recruiting motor units in synchrony, not from muscle hypertrophy,” I explained my reasoning further.

To me, even if some component of “won't” contributed to VA's snowball to inactivity that led to his immobility, he was not physically capable of moving his legs in his current deconditioned state. He weighed 450 lbs. His legs were heavy, and he had not moved them for several years. Even if the intact neural connections were sending signals to his leg muscles, he could not recruit his motor units properly, in synergy as necessary—it was a “mind-body disconnection”—and thus he currently did not possess the strength needed to move his legs' weight against gravity. He needed intensive physical therapy to “wake up” his neuromuscular modalities.

Our collegial intellectual debate aside, the attending and I both agreed that the right combination of medication management, psychological support, and physical and occupational therapy could get VA walking again. Right away, VA plugged into the treatment system and was off and running (though he was still sitting in his motorized wheelchair): he pushed himself in physical therapy twice per day and participated actively in three group activities in the afternoons. In parallel, the attending psychiatrist started an opioid taper to slowly wean VA off of pain “blockers”—morphine, oxycodone, etc.—while simultaneously adding therapeutic medications for his mood and pain—lithium, nortriptyline, etc.

“Let me see you move your feet,” the attending said the next morning on rounds. “I can only wiggle my toes a little bit,” VA replied. “That's OK. I want you to elevate your legs for 15 minutes every hour to help get the swelling down. And when you elevate your legs, I want you to practice wiggling your toes,” the attending instructed VA. The next morning on rounds, the attending started the conversation similarly, “I want you to slide your feet back and forth.” “Like this,” VA said as he ever-so-slightly moved his toes one centimeter to the right, and then another one centimeter to left, a restricted range of motion without much bandwidth. “Yes, just like that. That's great,” encouraged the attending.

“Get neurology to come look at this patient,” the attending said to me. “Can't or won't. That's the question,” he added.

Neurology's evaluation, which involved an electromyogram that was interpreted as normal, did not answer the question. “The wires are hooked up and working properly,” the psychiatry attending said after I shared with him the neurology workup results. “What about an amytal interview? That would help us answer the question,” he finished.

Amytal is a barbiturate derivative that acts as a sedative-hypnotic drug that psychiatrists use as “truth serum”: as the amytal is slowly infused intravenously into patients, psychiatrists start to

use psychological techniques to either get patients to share information that they have been concealing or to disinhibit patients so that they display behaviors that they either have been hiding or did not know they were capable of accomplishing. In VA's case, the attending hypothesized that an amytal interview would disinhibit VA and allow him to stand up and walk.

I disagreed but was open to the possibility. My interactions with VA had all been genuine. He was in pain. He was not faking. He was giving honest efforts to move right now but could not. Sure, he was scared about weaning off of his opioids—he thought his pain would increase—but he was committed to physical therapy and was working hard each day to “wake up” his legs. I kept encouraging him to be patient and to keep moving his toes, then his feet, as much as possible. I seconded the attending psychiatrist's message: “You'll walk again.” The fact that the attending thought “won't” and I thought “can't” did not interfere with VA's patient care; we were on the same page and both shared the same primary goal: resurrect VA's life. We worked together in hopes of getting VA back on his feet.

“How much am I going to get?” the attending asked me quietly as the anesthesiologist started VA's amytal IV infusion. “Not much,” I replied, implying that I did not think that VA would be able to get out of his wheelchair and move about the room. As the anesthesiologist uptitrated the amytal slowly, VA felt more and more sedated. Now ten days into his stay on our service, VA could move both of his feet while seated in his wheelchair; he was making steady improvements with twice-daily intensive physical therapy. “Hold my hands. I'm going to pull you up out of your chair, and you're going to stand,” the attending told VA. VA grabbed the attending's hands: “One. Two. Three. Stand!” the attending called out like a coach as he pulled. We discussed with VA that this procedure was a way for us to help him dissociate his pain from his leg movements; a way to disinhibit him so that we could see how much movement he could do. Toe-to-toe with VA, the attending pulled VA forward by the arms, elevating his bottom up out of the wheelchair by a few inches: “Look at you; you're standing!” the attending exclaimed. Of course, VA was not standing fully, but he was up out of his chair partially; another positive small step in his progress. “You did great! You were standing,” the attending reiterated—celebrated.

The truth serum revealed the truth: VA could not stand. He could not walk. The answer, for the moment, was “can't.”

The next two weeks were filled with more one-foot-in-front-of-the-other baby steps. The attending replaced VA's electronic wheelchair with a manual one. We told VA to view the manual wheelchair as a way to work out his arms even more to help him gain strength and accelerate his weight loss. VA was watching his diet diligently and was losing weight quickly. Now down to 395 lbs., VA was getting into shape.

“Check this out,” VA said to me, pointing to his phone. He showed me a picture of him, making a thumbs-up sign and smiling, strapped into a gigantic harness at physical therapy that morning. The harness held VA up so that he could use parallel bars (set up at about waist height) to hold his body up while simulating standing. He then moved his legs back and forth, floating a few inches above the ground. His legs were not yet strong enough to bear his body weight, but while supported in the harness, he could move his legs. He was another step closer to walking.

“It’s weird. I thought that my pain would go up as you guys took me off of my meds, but my pain has actually improved. It’s now like a 4 or 5 out of 10, when it used to be a 10 out of 10 constantly. I almost want to finish the taper quickly to get off of the oxycodone faster and be done with it,” VA said to the team on rounds one morning. “That’s good to hear, but we’ll still go slow; you’re doing well this way,” replied the attending. VA had ridden a rollercoaster of symptomatic ups and downs, as expected, as the dosages of his opioids were decreased: chills, sweats, diarrhea, and fluctuating moods were infiltrating VA’s days, but he was muddling through the taper safely. He stayed positive throughout: he prayed; he used mindfulness exercises; he turned to meditation—he persevered.

And soon the rainbow appeared.

On morning rounds, just like in the amytal interview, the attending stood toe-to-toe with VA as he sat in his wheelchair. They locked hands, and on the count of three, the attending pulled VA up to stand: he locked his legs. He was standing.

A few days later, with momentum building, VA turned the table on the team; it was his turn to show us a new breakthrough. At physical therapy recently, he had been practicing using a walker to stand. This morning, he placed the walker in front of his wheelchair, grabbed the walker sturdily, and pulled himself up out of the wheelchair, standing up on his own terms. And then he took two steps. “Amazing! Do you see how great you’re doing? You’re doing great!” celebrated the attending in concert with the rest of the applauding, elated team.

Each day for the rest of the week, VA walked 20 feet with the walker. It took him thirty minutes to walk 20 feet, but his snail’s pace was quite a feat. Over the next few weeks, he eventually freed himself from the walker: he was walking gingerly on his own two feet.

His mom visited and cried with joy: “I have my son back,” she exalted.

“I’ve been thinking about it; I want to be a nurse practitioner—I want to help people who are in pain,” VA told me. He reflected further: “I remember my first day here, when you got my mom a cup of coffee. I didn’t believe you guys when you said I would walk again. I didn’t believe you guys when you said that my pain would improve as I came off of my meds. But I did believe that you were there for me; that you were committed to helping me.”

Another week passed, and VA was walking all over the hospital campus. He still tired easily, and he took breaks frequently—his feet were “sore puppies”—but he was walking as much as possible and started to feel like himself again. He had pep in his step. He had his life back.

I filmed a short video clip of VA walking down the hall: “Here comes VA, walking like a champ,” I narrated as VA strolled towards me, displaying a warm smile that lit up his face, lit up the hallway. I shared the video with VA’s mom; and, taken aback, VA’s mom responded back:

“A miracle occurred. Thanks for giving me my son back.”

A resurrection miracle indeed—teaching a lesson to heed:

In some cases of “Can’t or won’t,” it’s a little bit of both.

“Heartbeats”

By Anonymous (**Osler** College?!?!)

It is most dangerous
being a physician
raised high
like a god, above and beyond
in all power, authority, ability.

It is most dangerous
the responsibility
to cure care condemn
the disease, note: not the patient.

Beware of how the patient might react
when hands twist and press the skin,
when ears fail to listen to flickering eyes.
Did you see too, the confusion, wordless, as
the stethoscope roped itself across his chest?

A comment was made, an obscure, wonderful finding
and then the pleasure of twittering colleagues.
Upon the bed, the patient is no more
than an irregular heartbeat,
a thrusting call from the grave.

The Irregular Heartbeat

By Wuroh Timbo, MSIV (**Nathans** College!)

Your source for what’s going on in The Hopkins Med student body.

NOTE: This is meant to be satirical (similar to The Onion); all quotes and events may in fact be exaggerated, fabricated, or just plain wrong.

“Rising 3rd Year Students Get Top Picks for Clinicals”

Entering the wards as a second year student has always been one of the most anxious and exciting times in a medical school journey. Perhaps one of the biggest sources of angst is determining one's clinical schedule, followed by dreaming that the writing on that piece of paper is actually honored.

For the many of us who have gone through this process, we know that making it to that REM stage is more elusive than initially let on. And the dream of a perfect...or near perfect...or even *halfway decent* schedule is abruptly halted at the wall of realism. If we could grade the correlation of our schedule to what we initially requested, many of us would passive aggressively drop a 3-bomb on our schedule's gluteus.

The hours and hours of toiling over what the best combination of 1st choice, 2nd choice requests seem almost comical when our schedule reveals a succession of 0th choices. Some have resulted to personal pleas of desperation when filling out their schedules. Notes like, "Please, please, please, please, please, please, do not put me in surgery...like...ever," or, "I don't like kids," are tossed around with the hope that the passion they've expressed about the clerkships they DON'T want to take early on goes recognized. Unfortunately, the opposite often happens, and many of these students are given the rotations they lose sleep over within their first three quarters.

This year, however, marks a shift from the norm. Instead of the cries for mutiny and riot that some have become accustomed to hearing once schedules are released, AMEB has been full of cheers and frivolity. As it turns out, many students in the second year class were pleasantly surprised to see their ideal schedules gifted to them. What was responsible for this sudden radical change in the norm?

“Well, we all got to talking,” said one rising third year, “and we noticed something. Everyone was getting their least favorite options after requesting what they ideally wanted. So, what if you requested the schedule you would literally pay to never have to take. Would you get the opposite? It was risky, but we decided to give it a try.”

Brilliant.

“And for the most part, it worked out: students were really happy with their schedules. In retrospect, it seems so simple—I don’t know why no other class has tried it before.”

It seems these Med Studs have caught on to something. And I’m sure with this newfound knowledge, the trend will continue.

“I think that’s the beauty of the Hopkins system,” said one member in the Registrar’s Office: “At any other program that uses an electronic system to determine schedules, this plan would never have worked. However quickly and efficiently an electronic system would have worked, this system would have given students their requested schedule choices, and these students would have unfortunately been stuck with a less than ideal schedule. But with everything here done on paper, of course we would never expect that to happen.”

Would never expect it to happen, indeed.

But like when a stone is dropped in a river, the ripples inevitably correct themselves to flow back with the current. How long can such a strategy work? Will the powers that be correct the system to allow for students to get their desired choices upon request? Or, will they just stop taking schedule requests all together? Either way, one thing is certain: if we had an electronic scheduling system capable of comprehending what was happening, the mixed messages sent by students this year may have been too much for the CPU to process, and the whole system likely

would have crashed. And for this reason, we are thankful for Hopkins' dedication to addressing the global overpopulation of trees via this paper system.

Bravo, Hopkins. Bravo.