

Our lives are dedicated to yours

ISSUE HIGHLIGHTS

Welcoming the new year with a new fresh layout!

New members, new stories, new perspectives...

Creative art pieces from a medical perspective.

Ra

Radioactive

AUBFM NEWSLETTER

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Fatima Chamseddine

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MUSIC IS SCIENCE...
MUSIC CAN HEAL

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INTO POWER

AND MUCH MORE...

EDITOR IN CHIEF MESSAGE

Rawan Safa, Med III

The symbol "Ra" was chosen as our logo since it stands for Radium, a chemical element that possesses several isotopes, all that are radioactive. Radioactivity refers to the spark that this newsletter emits. A spark created by the collision and pile-up of multiple forces: medical students, research assistants, medical residents, nursing students, attending physicians, and many more.

Radioactive has become the platform for all health care individuals at AUBMC to vocalize their concerns, raise awareness, and relay their opinion. Our newsletter has been growing over the past four years with new concepts, ideas, and designs. The dedication and hard work of the board members, along with the interesting viewpoints of the students and doctors, has resulted in delivering this adequate issue with high quality topics and interests.

In this issue, our change in design was made to be more reader friendly, and encompass more articles. This issue covers multiple topics including women's health and stigma, the power of neurological music therapy, reflections on research, the difficulties in communicating with patients, and many more. We are trying to also step behind the white coat, and get to know our physicians in their daily lives. I am grateful for the opportunity to work with the board on this issue, and I look forward for the feedback that will push our newsletter even further.

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BRIEF REFLECTIONS ON MEDICINE

Dr. Fadlo Khuri, MD, President of American University of Beirut

"In a word the purpose of the college is not to produce singly or chiefly men who are doctors, men who are pharmacists, men who are merchants, men who are preachers, teachers, lawyers, editors, statesmen; but it is the purpose of the college to produce doctors who are men, pharmacists who are men, merchants who are men, preachers, teachers, lawyers, editors, statesmen, who are men."

You will be able to tell from some of the references in this resounding quotation that the text was not taken from my presidential address at this year's AUB Opening Ceremony! In fact they were the words of our second president Howard Bliss during his baccalaureate sermon in 1911, when the American University of Beirut was still operating under the name of the Syrian Protestant College and we had yet to graduate our first woman student. But the sense is clear. The American liberal arts model of education, which AUB follows to this day, is not restricted to producing men and women trained for excellence in professional careers such as medicine, nursing, engineering, architecture, etc. But it is also a moral imperative and practical advantage, in our view, to produce well-rounded individuals who may be excellent doctors, or nurses or engineers, but more importantly they are women and men of integrity, creativity, open-mindedness, individual and social responsibility.

AUB medical students are indeed a special breed. Filled with hope and conviction, among the best and brightest members of a community that prides itself on its intellect and application, our medical students enter our soon to be 150 year old medical school convinced that they can change the world for the better. And generation after generation, our medical alumni have done just that, as you too will one day. But it is worth reminding ourselves of a few things before we go forward at full throttle into a daunting and demanding world. I have some brief advice to share with our wonderful AUB students learned during my 27 years in this most noble profession we will soon share.

First, the pressure to perform affects all of us. Fueled by our competitive juices, and dragged down by fatigue, cutting corners to get ahead can become a natural human instinct. When this temptation or other difficult choices present themselves to you, think twice and weigh your options thoroughly, and most of all check your moral fiber. Your conscience and desire to first do no harm should govern your decisions in these challenging times. Slow things down and break down the components and consequences of your decisions rather than speeding them up. Wise decisions more often emerge when one deliberates carefully.

Second, try at all times to remember that the physician-patient bond represents a river that flows both ways: empathy and sagacity from the physician and gratitude and humanity from the patient. Both sides derive great reward and satisfaction from this vital bond. It is not a one-way street and you are serving your patients because you have the training, skill and privilege to do so. It is an honor and not a favor to be a true physician, a gifted healer. Enjoy these gifts and deploy them wisely.

Third, remember that medicine (and in fact life) is a marathon. Don't burden yourself with the thoughts that your career and your life are on the line with every decision. We learn from our mistakes and we become wiser by doing so. Becoming forgiving and understanding with your peers, colleagues and patients will help you accept your own stumbles more readily. "Judge not lest ye yourselves be judged", as the biblical phrase goes. Mercy is an essential quality of physicians, nurses and caregivers. Let mercy be your guide and the times will pass more peacefully and the results will flow more readily.

Finally, read, read and read some more. Being a perpetual student of life, medicine and science is not only a wonderful privilege but a great opportunity. And the opposite, failing to keep up with the medical and scientific literature often has dire consequences, for you and your patients. Another of my favorite quotations, by William Osler, a founder of modern American medical education, is that "It astonishes me how many physicians practice medicine without reading. What does not surprise me in the least is how poorly they do so!"

But most of all, as my great friend Bill Eley, Dean of Medical Education at Emory University has said to me on many stressful occasions: **"Enjoy the journey." Medicine is empowering, engaging and genuinely enthralling.** You are on the cusp of joining a matchless sisterhood and brotherhood. **Savor every moment of it.** We at AUB have no doubt that you will make us very proud, and we look forward to welcoming you into the profession as our future colleagues.

Go in peace and in purpose, my younger brothers and sisters. You will get there.

MUSIC IS SCIENCE... MUSIC CAN HEAL: THE POWER OF NEUROLOGICAL MUSIC THERAPY

Faysal Tabbara, Med II

Music is a powerful universal language - so much so that even a fetus can respond to it. Many studies have linked exposure to music in utero to the stimulation of the baby's growing brain. Music elicits many different types of emotions, making us cry, laugh, love and dream. But have you ever wondered why? Or how it works? Or if music can be used therapeutically? My passion for music took me on a journey with Mr. Brian Harris, a Board Certified Neurologic Music Therapist and CEO of MEDRhythms, who I had the great opportunity to shadow at the Spaulding Rehabilitation Hospital in Boston, MA.

Music therapy uses evidence-based interventions such as improvising, listening, singing and moving to help patients improve their physical, mental, social and emotional health in a clinical context. Music therapy relies on the assumption that humans have an innate ability to respond to rhythm. Neurologic music therapy is a subspecialty that focuses on the application of music in managing various neurologic disorders, such as sensorimotor, speech/language or cognition disorders. Patients with stroke, traumatic brain injuries, Parkinson's Disease, Alzheimer's Disease, Huntington's Disease, Cerebral Palsy, and autism, among many others, could benefit from these neurorehabilitation services.

Therapeutic applications include "Rhythmic Entrainment," which uses the periodicity of auditory rhythmic patterns to improve spatial parameters in patients with movement disorders. Patients experiencing language and speech disorders could benefit from "Rhythmic Speech Cuing," in which the initiation and rate of speech is controlled via rhythmic cuing and pacing. Additionally, patients can engage in "Melodic Intonation Therapy," where a patient's unimpaired ability to sing is utilized to facilitate spontaneous and voluntary speech through melodies. These techniques constitute only a few samples of the developments that target various neurologic disorders.

Music was also found to enhance the neuroplasticity of the injured brain, thus improving the healing process. Mr. Harris explains, "Our patients are recovering faster, with greater results, and sometimes music is the only stimulus that can drive these improved outcomes. The cutting edge neuroscience research supports the profound impact of music on non-musical functions in the brain, as well as music's ability to aid in neuroplasticity, which can explain why these outcomes are possible."

Studies using functional MRI and PET scans have highlighted the different neural networks that interpret the various properties of music. Between the right temporal lobe (pitch perception), the cerebellum (rhythm processing), and the frontal cortex (emotional content), we clearly see how the brain's magnificent wiring system makes it such a special organ.

Music therapy miraculously helps patients regain their ability to speak, walk, and move among other functions. No words can adequately describe my astonishment upon witnessing the effect of music on patients following neurorehabilitation. Their beaming smiles after therapy are a reminder of how music can significantly improve their quality of life and overall wellbeing. This booming field has the potential to shape the quality of medical care delivered. I personally hope that awareness about the healing power of music spreads until it is practiced everywhere around the world.

OUT LOUD!

Q WHAT DO YOU THINK ABOUT THE FIELD OF NEUROLOGIC MUSIC THERAPY?

A



“The more that we learn about music’s profound impact on the human brain, it will change the future of healthcare, and more specifically, neurorehabilitation.”

*Brian Harris, CEO of MEDRhythms,
Neurologic Music Therapist*

A

“I always listen to music while studying, and I think that it helps me improve my cognitive abilities. I look forward to learn more about the neuroscience behind music.”

Serena Saade, Med II



THE DOCTORS' GAP

Malak El Sabeh, Med I

The weather is crisp and chilly, the ideal autumn weather. I hold on to my warm cup of coffee, relishing the last few sips. Bliss Street is loud and bustling. The cars are crammed, and the street is full of hurried students. I close my white coat, trying to get some warmth and check my watch. *I am so late.*

I walk past Urbanista, Zaatar w Zeit, and cross the road. I continue walking upwards, drink the rest of my coffee, then toss the empty cup in the large, overflowing garbage bin. The pile of trash is almost animated. I cringe and increase my pace to walk past it.

I reach Casper and Gambini's which, as always, is full of doctors mulling over lattes and bite-sized desserts. Everyone seems so calm inside. I envy their calmness while turning left to face AUBMC's building ahead. Good, I'll make it just on time. Right next to the restaurant sits a dark skinned, disheveled beggar on the sidewalk. His leg, pronouncedly defected, is extended forward, with his foot placed in an unusual angle. His eyes, pleading. I cross the road to avoid walking next to him.

AUBMC at last.

I walk up the stairs, to my patient's floor. Before knocking on the door, I fix my hair and make sure that I look presentable. With a smile, I enter the room. After a lengthy conversation, I check the vital signs and rest assured that the patient is doing well with no complications. Before leaving the room, we exchange a few more words, and I make sure the patient is relaxed and at ease and does not have any other concerns.

I walk back to my car at night after a busy day. The beggar is no longer there. In the darkness, you cannot really distinguish the pile of garbage anymore; it has been engulfed by the sidewalk, a peripheral obstacle I rush by. And I realize, that maybe, just maybe, it is far easier to live this way.

We often justify ignoring what is happening around us with the excuse that we already have a plate full of obligations. As a doctor, one has a myriad of responsibilities that are intrinsic to the often selfless and demanding nature of the position. Perhaps, it is this overwhelming sense of responsibility in the hospital that makes it more difficult to be everything all at once: a healer, a public health advocate, a daughter, a philanthropist, a friend, simply and unapologetically a human... On Bliss Street once again, my thoughts drift back into the pleading eyes of the beggar and the smile of my patient. How different life can be for each and every person.

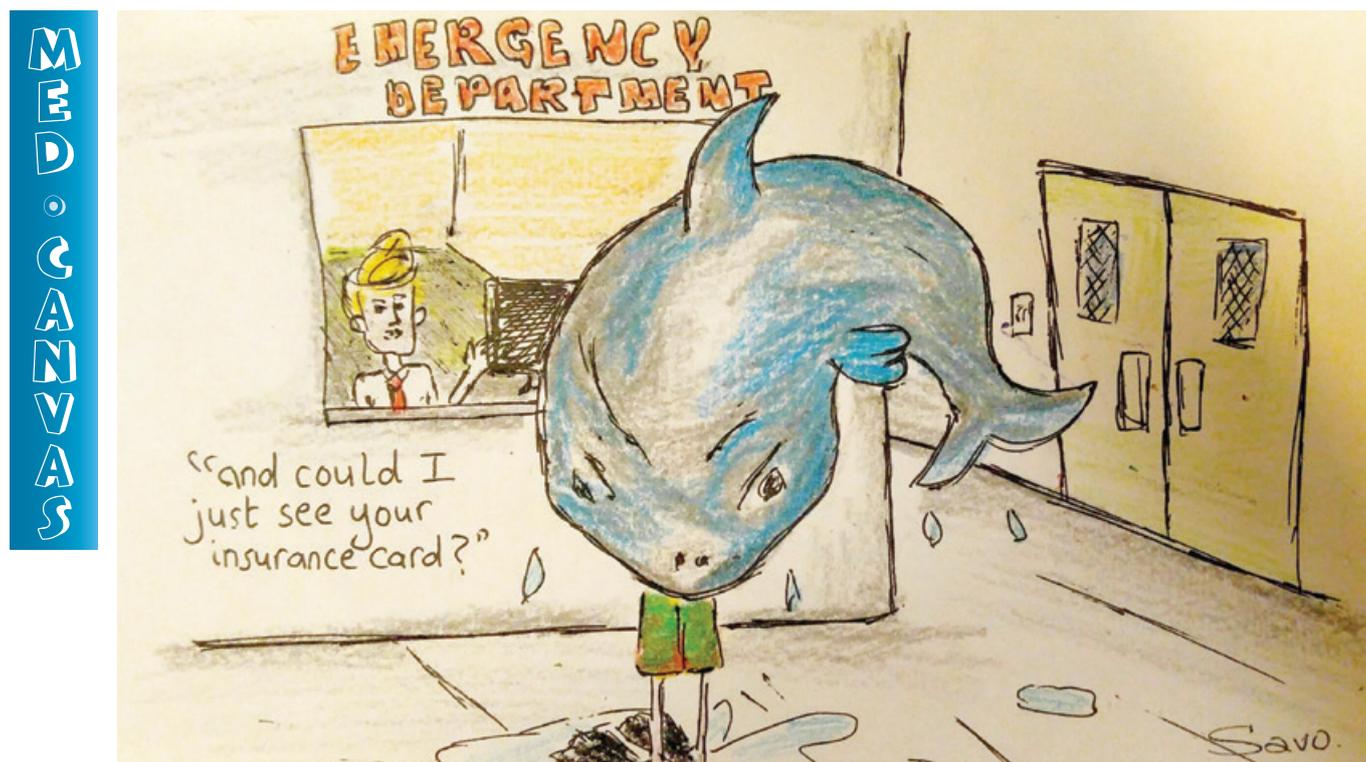


Illustration by: Savo Zeineddine (Source: Reader's Digest)

BREATH-WHERE DEATH AND LIFE TANGO

Sarah El Halabi, Med III

“When Breath Becomes Air” is an autobiography written by neurosurgeon Paul Kalanithi, following his diagnosis with lung cancer. Throughout his book, Kalanithi invites us into his life to engage with important family members such as his wife, Lucy, and his future daughter, Elizabeth.

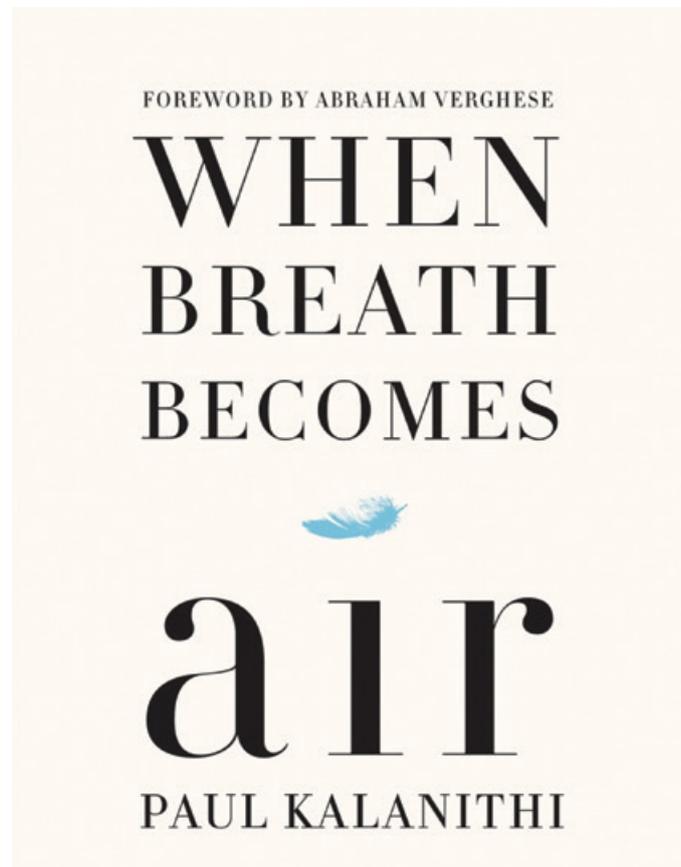
The first part of the book discusses Dr. Kalanithi’s childhood, teenage years, and career choices. His father, a physician, was devoted to his patients and career to the extent that young Kalanithi barely saw him. Subsequently, Kalanithi adamantly refuses to pursue a medical degree, studying literature instead. This does little to suppress his fascination with human behavior and the brain, and he ultimately joins Yale’s School of Medicine.

As we follow the story of Kalanithi’s training, we are taken aboard an emotional rollercoaster, from the sorrow of the death of his first patient to the satisfaction that comes with the realization that his calling is to become a neurosurgeon. Through Kalanithi’s experience, we see that medicine is a mentally and physically taxing occupation. Kalanithi is relieved to lay his back on the OR walls for a slight second, just to pause and take a breath. At this stage of his life, breathing is still an ordinary phenomenon, devoid of the existential crisis that ensues his diagnosis.

Pause.

Dressed as a patient, Kalanithi stares at his own CT, marveling at it and at the irony of his life. We too are struck by the same irony, as we watch Kalanithi transition from an accomplished neurosurgeon to a terminally ill patient. Yet, throughout all these bleak developments, Kalanithi and his wife have a baby: the prospect of life contrasting with the prospect of death. Chemotherapy lends Kalanithi time, but like the breath that is inhaled and must be exhaled, his journey soon comes to an end. Kalanithi eventually dies with his family by his side, a family that withstood the test of emotional pain and fatigue, but most importantly a family that celebrated the ephemeral- a short bittersweet life that refused to be dictated by the changes that pained it.

The Kalanithis teach us that our ability to embrace everything that comes our way is by far the greatest element that determines how well we have lived. To me, “When Breath Becomes Air” is a story about growth, sickness, family, and pain. Most importantly, it’s about human ability to find serenity in the very heart of disappointment.



Source: <http://paulkalanithi.com/>

LOST IN TRANSLATION: MEDICINE IN A TRILINGUAL COUNTRY

Khalil Baddour, Med II

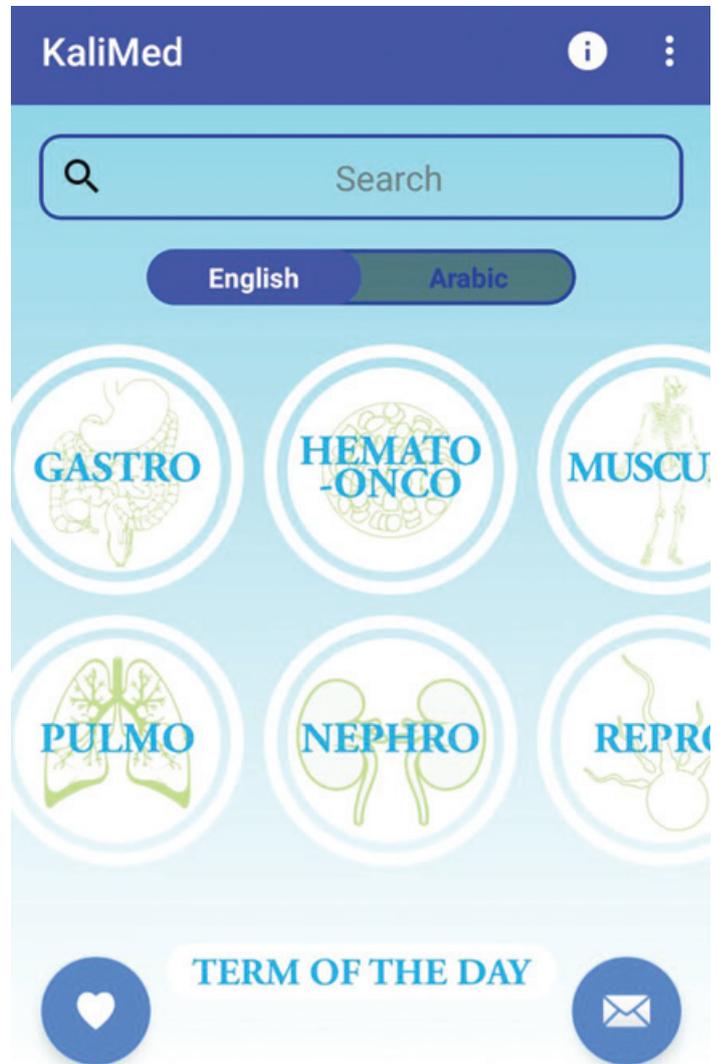
“Ascites? How do you say that in Arabic?” Around the time of every OSCE exam, medical students scramble to translate a module’s worth of medical terms into spoken Lebanese Arabic in order to interact with their mock patients in the same way they will one day be expected to interact with actual patients. Some call their parents for the first time in months, some consult family friends who are physicians, while others spend hours on Google translate. Each one resorts to a personal strategy that would help overcome this inevitable inconvenience in a trilingual society.

AUB Medical students are trapped between an English-based medical education and an Arabic-speaking society that, in itself, is also highly influenced by its history of French colonization. One would think that this would be an asset on the hospital floor, and it is – especially abroad. But closer to home, it could be quite cumbersome for both the physicians and the patients. As physicians, we are consistently acting as multilingual translators in order to bridge the gap between the theory in English and the practice in Arabic.

In addition to the specific trilingual context of Lebanon, the world of healthcare – as if to distance itself from society even further – has developed a sophisticated jargon that is chock-full of words you would never understand unless you were part of its community. It would be safe to assume that “glomerulonephritis” or “encephalopathy” are not words children might learn or encounter throughout their life unless they find themselves in a medical school or a hospital. For a profession that is heavily rooted in daily interaction with laypeople from all sorts of backgrounds, its mission is contradicted by the complex and inaccessible language it depends on.

Although these barriers are nothing new to the world of healthcare and medicine, various efforts have been made to close the gap between physician and patient communication through dictionaries, books, and other various tools. It is only natural that these efforts follow the technological trends and progressively move from hardcover encyclopedias to applications on the mobile device in the palm of our hand. The latest addition to our arsenal is “KaliMed,” an application designed by members of the Standing Committee on Medical Education (SCOME) of the Lebanese Medical Students’ International Committee (LeMSIC). The phone application is the first of its kind in that it translates English medical terms into their colloquial and proper Arabic equivalents, thus aiding both medical staff and patients in moving towards a better understanding and clearer communication.

In a globalized world, and an evermore Westward-looking society, we as members of the Lebanese medical community sometimes fall short of our duty towards patients in terms of providing them with accurate and accessible information regardless of their social status or educational level. This is not due to a lack of effort but simply because we do not have tools that facilitate appropriate communication. Now, there seems to be a silver lining on the horizon and one day, translating “ascites” will be a few finger taps away.



OUT LOUD!

Q HOW DO YOU THINK WE, AS ENGLISH-TAUGHT, MEDICAL JARGON-SPEAKING PHYSICIANS IN AN ARABIC-SPEAKING SOCIETY, SHOULD ADDRESS THE LANGUAGE BARRIERS IN OUR PRACTICE?

A



“Including language targeted courses, and even having some OSCE sessions in Arabic would better prepare the medical student for his or her future practice.”

Sarah Abi Raad, Med I

A

“Being from an Arabic country, physicians should learn the basic anatomy in Arabic. It is always a plus to aid our learning by converting it to our first language in both its common and slant terms like we did in Kalimed.”

Mouafak Homsy, Med II



NEVER SHOCK ASYSTOLE

Raji Naamani, Med II

Never shock asystole. How many times have you seen a patient flatline on television, only to be “defibrillated” back into a stable sinus rhythm? Does it not surprise you that CPR procedures and epinephrine injections were nowhere to be found? Just like attempting to restart a computer while the power is out, several representations of medicine in the media throughout history have been simply illogical.

In the past 50 years, there have been at least 70 medically-set TV programs, many of which ranked among the highest-rated shows of their time. In spite of all the actors and scripts, medical dramas offer a behind-the-scenes glimpse into the management of a hospital that often seems quite real. Ultimately, however, these dramas are just that: dramas – predicated on conflict, protagonists, antagonists, and life versus death situations. It is almost as though medicine is a natural fit for television by virtue of having many of these elements at play on a routine day.

Over their past few decades on television, doctors have regressed from the infallible figures they were once depicted as. Today, if ‘TV docs’ possess glowing good looks – they are arrogant. If they excel clinically – they are contrasted with a god complex. If they are perfectly well-mannered – they are downplayed and shown as weak (Tapper, 2010). Some portrayals have even devolved to drug-addicted, prostitute-abusing antiheroes. While researchers acknowledge a shift towards a less positive image, some doctors claim it is a more accurate description than the classics; physicians are only human, and they do make mistakes.

Modern television tends to place medical professionals in a muddled work-life balance, with their social and professional lives almost totally intertwined. “Scrubs” has often been voted the most relatable medical TV series by physicians; it shows that doctors truly care about their patients, while featuring some dark humor and realistic human interactions. “House, MD” owes its popularity to the extreme medical cases and diagnostic problem solving skills. “ER” appeals to its audience by dramatizing emergency cases, while “Grey’s Anatomy” does so by keeping sexual connections in the workplace at its center.

“ I have always felt that the TV docs had a much better work-life balance than I do. They also have a lot more intrigue in their life – I haven’t had any affairs with co-workers, I haven’t turned up with some sort of rare disease that I need to find the cure for, and I am not being manipulated by the mob to do their dirty work. I guess that’s why I haven’t ended up with my own TV show. I wouldn’t have time to watch it anyway. ”

Elizabeth H. Sinz, MD: Professor of Anesthesiology and Neurosurgery and Associate Dean for clinic simulation at Penn State Hershey Medical Center

Misrepresentation of medicine in the media strongly influences patients' expectations; it creates a gap between reality and what is captured on screen. Extreme (and sometimes fictional) medical conditions and treatments fall on the rare end of the spectrum, but such phenomenal themes have become the norm in the public eye. During a hospital visit, some patients may expect either a medical miracle or a medical error, whereas both might be exceedingly uncommon. Furthermore, if the quality of care provided is perceived as inadequate, patients and their families often suspect malpractice. This puts doctors in an unsteady position – trying to meet inflated expectations while managing a patient's mistrust.

As physicians, we are often able to resuscitate and stabilize our patients, but this requires more than the small sample of steps that seem exciting enough to show on television. In the matter of building patients' trust, we, as medical professionals, must aim to bridge the gap and move towards a solution. We have seen doctors evolving into bioethicists, consultants, and even business (hospital) managers. Why not divert some attention to our portrayal by the media? We have experienced firsthand how it can sway an audience.

References:

Tapper, E. (2017). *Doctors on display: the evolution of television's doctors*. PubMed Central (PMC).

“Doctor shows bring viewers behind the scenes to portray how health-care providers behave when they and their patients are in crisis... A study we |conducted . . . found that just about every medical series had at least one major malpractice story line. The doctors were often at fault. . . TV's continual message is that doctors are quite fallible. That may well frighten many patients. ”

Joseph Turow, Professor of Communication at the University of Pennsylvania and creator of "Prime Time Doctors: Why Should You Care?" [DVD]



DISEASE TURNED INTO POWER

Martin Karam, Research Assistant at AUBMC

Ever looked at a beautiful painting and thought it was a work of art? Ever thought about the circumstances surrounding the creation of such works of art? At its essence, art is about the feelings and emotions that strike observers as they inspect a particular piece; they reflect the tangible feelings and emotions that inspired its creator. In art, the physical, mental and emotional struggles of the artist play a major role in the final work.

Health is not conventionally considered directly related to art, yet it plays an important role in major art creations by affecting the artist during the time he/ she is producing the piece at hand. One poet, Sylvia Plath, suffered from clinical depression and attempted suicide several times before she finally succeeded in taking her own life in 1963. While problems with mental health should not be romanticized and should ultimately be addressed by professionals, Plath's most influential and intense poems were written during her darkest times when she was struggling with severe depression. During those times, she communicated her pain and misery through her writing.



Illustration by: Martin Karam

Another notable example of mental health affecting the process of art is observed in Pablo Picasso's "blue period". Picasso suffered from depression, and throughout this period, his drawings were all depicted in shades of blue, black, and grey with an abundance of figures representing the poor, miserable, and unfortunate. Picasso's paintings conveyed immense feelings of tragedy and sorrow. Among these is the very famous "The Old Guitarist," which represents the life of an artist whose career became his life and source of distress simultaneously.

Sometimes, the health of the artist plays a physical role in their productions. In the case of Frida Kahlo, the initial drive to create art was triggered by her health condition. Frida only started painting because she was bedridden following severe physical trauma from a traffic accident that led to her becoming paralyzed while maintaining the ability to move her hands. Her pain and trauma were the main subjects reflected in many of her drawings that are revered and admired globally till this day.

Another famous artist and composer who suffered from deafness and yet was able to channel his physical disability into creativity is Ludwig Van Beethoven. He had to cut down the base of his piano so it lay directly on the floor, allowing him to feel the vibrations emitted, as he could not hear the sounds of the notes he was playing. Such a condition empowered the fully deaf Beethoven and resulted in the creation of Symphony No. 9, considered by many as the most famous piece of classical music.

At many times, the artist's artworks appear as a manifestation of the evolution of their health condition. Louis Wain was an English artist who is known for his anthropomorphized cat drawings back from the 1880s. Wain suffered from schizophrenia, and as his condition worsened, his drawings progressively became more and more abstract. Nowadays, his paintings are used as a reference to in many psychology textbooks. They exemplify the way a psychological condition can affect the style of an artist. Thus, art can even enhance the way we visualize and understand the mechanisms of various diseases.

Although health conditions of artists do manifest in their art, various other factors impact the final outcome of artists. Although these contexts add to the value of a piece of art, they come at a very expensive price: living with a chronic condition or disability. The next time you admire a work of art, try to speculate its context and the factors that urged the artist to produce it.

OUT LOUD!



WHAT EFFECTS DO YOU THINK HEALTH HAS ON ART?

A

“ I believe that art is an expression of the person’s emotions and experiences in life. If an individual suffers from a health condition, it will definitely show in his or her art but the way it shows is very personal and subjective. ”

Nadine El Hajj, PGY2 Emergency Medicine

A

“ To some people, their medical conditions are so severe, they impair their ability to produce art, to others they may act as the inspiration to produce even stronger and more intense art. ”

Rita Hleihel, PhD Candidate



SHAPING THE JOB YOU HAVE INTO THE JOB YOU WANT

Rawan Ghazzawi, Researcher at the Evidence-based Healthcare Management Unit (EHMU)

Recently, there has been a focus on the active role employees have in the workplace. Employees should no longer be perceived as passive recipients of their predetermined job descriptions but rather as “crafters” of their roles. Job crafting allows employees to change certain aspects of their jobs driven by the desire to have some control over their careers and willingness to achieve a positive self-image that satisfies their basic need for establishing relationships with others. Through increasing social and structural job resources, limiting unexpected job demands, and increasing challenging tasks, employees personalize their jobs and ultimately increase the meaningfulness of work and performance.

Job tailoring is particularly relevant in high stress environments, such as healthcare. The environment of healthcare is very challenging because of the high exposure to many physical and emotional demands. However, this provides the opportunity to customize one’s job and roles. Healthcare professionals could enroll in non-mandatory training programs where they can develop their own capabilities and learn new things. A pulmonologist, for example, could compliment his training with a specialization in sleep therapy; an oncologist, on the other hand, might consider enrolling in a workshop that targets developing emotional intelligence (EI) and that would serve as an added value in patient interaction.

Job crafting can also include more personal aspects. Employees can plan their work in a way that minimizes contact with colleagues who cause them emotional distress. Healthcare professionals can ask their managers to coach them and regularly seek advice from their colleagues to enhance their performance. By managing time more efficiently and learning how to be more proactive, employees can regularly take on extra tasks or volunteer to be project co-workers

Job crafting initiatives at work, unlike random proactive acts, are continuously demonstrated and incorporated into one’s job. They tend to satisfy the needs that the original job description couldn’t satisfy, thus enhancing the employee’s work experience, productivity, and sense of purpose.

“WHAT WAS YOUR SUMMER LIKE?”

Hiba Dagher, Med II

When you ask medical students about their summer, you probably expect to hear about clinical rotations and research projects. But if you probe a little further, you’ll hear a different kind of narrative, one with stories that do not meet usual expectations.

You’ll hear about the trip to Sri Lanka where students taught village children English or volunteered at an animal conservation facility and fed baby elephants. You’ll share moments about teaching first aid to Lebanese children through “Little Medical School”, or about the challenge of comforting a suffering family through SANAD. You’ll hear about the rewarding feeling of cooking an Iftar dinner for the homeless, or making a deal with the village municipality to collect donated books and open a small children’s library in the Bekaa area.

You’ll laugh with them about the funny moments, like the time they signed up for improvisation acting classes, or relied on Duolingo Spanish skills to get around Mexico. You’ll feel the pride and accomplishment as they describe biking 17 Km along the coast of Ireland or winning the “can-you-finish-520-grams-of-meat” challenge in Portugal. They’ll ramble about museums and exhibitions, or divulge embracing moments of unleashing their inner spice-girl and bellowing “Wanna be” in a Lithuanian karaoke bar.

The stories are endless, and they’re proof of just how out-of-the-ordinary our lives can be! As medical students, we’re expected to constantly invest in our medical careers and polish up our resumes. We’re supposed to be more academically productive with each passing day. Yet it is these very moments, outside libraries and hospital wards, that shape us into the types of people and doctors we want to be. Whether it’s using creative methods to communicate in Mexico, challenging ourselves on an improv stage, or stepping into the spotlight at a karaoke bar, each one of these experiences adds a beautiful new shade of color to our personalities as future physicians. We owe it to ourselves and our future patients to develop our characters, and not just our knowledge, because being relatable and able to communicate with patients are skills necessary for every successful doctor. So, in the next vacation you have, take the time to reach out, discover new interests and create new and unforgettable experiences.

OUT LOUD!



HOW DO YOU THINK JOB CRAFTING CAN IMPACT THE MEDICAL PRACTICE?

A



“ Re-crafting through small changes of care delivery and time management may well bring excitement and better service delivery to what could be really monotonous work. This may require re-framing how one perceives her job and that is where mindfulness is critical for a happier job performance. ”

Ghassan Hamadeh, MD

A

“ Crafting our own job probably leads to improved well-being, increased self-satisfaction, motivation and willingness to give more to the job itself, to people we work with, to patients, and to the society as a whole. Additionally, it makes it easier for us to surpass challenges at work and personally grow from them. ”

Nour Hassan, Evidence Based Healthcare Management- Unit Coordinator



INTERVIEW WITH DR. HASSAN EL SOLH

Interview was conducted by Rawan Safa and Sima Sharara, Med III

Q: What is the biggest difficulty you have faced throughout your career? How did you manage it?

A: My biggest challenge as a physician was making a decision at a crossroad: whether to pursue my clinical practice along with research or engage in administrative work alongside my clinical practice. As I became more involved in administrative work, the challenge of reducing my time and commitment to my clinical practice became even more difficult. The interaction with people is what kept me in my practice. Moreover, my clinical practice is always my guide to receive first-hand information from the patient experience in order to make well-informed decisions.

Q: What drove you into the professional administrative positions during your medical practice?

A: It is my need to establish systems and implement them on ground with evidence-based medicine that drove me into this job. I want to push the operations in the right direction, with the right coordination, integration, and structure, and without any fragmentation. This will result in complete focus on patient and quality of care, which is my utmost goal.

Q: Where do you hope to see AUBMC in 50 years?

A: I believe in both short-term and long-term measures. To become a world leading and world-class center of excellence in all our different subspecialties in 50 years, we need to start with our short-term vision. Our 2020 Vision is patient-focused rather than staff focused. We want our patients to have the best experience, rather than achieving satisfaction only. It is part of our plan to develop the most advanced education and training in the region and internationally, particularly with ACGME accreditation. We also aim to promote our 3 pillars: research, patient care, and accreditation.

Q: What is it about AUBMC that you think is so special and different from all the other medical centers in the Middle East?

A: I believe we are capable of providing comprehensive care for patients with our diverse specialties, expertise, and know-how. We own the most advanced diagnostic and therapeutic protocols and treatments, as well as the highest standards of education and research. Research has actually been the driving force for excellence in health care, and this is what differentiates us from others.

Q: When you were in medical school, how did you finally come to choose your specialty?

A: I believe pediatrics hematology/oncology is a challenging specialty encompassing all pediatrics' subspecialties. My decision was finalized as a pediatrics resident at AUBMC, by making me more interested compassionately. My patient, a 14-year-old child, relapsed after being treated for leukemia. There were limited second lines of treatment. The child always asked for help, and the team was always helpless. He asked me earlier on the day he passed away, "Are you telling me, as my doctor, that there is nothing you can do to save my life?". It is that question that took me in this direction.

Q: : What is your favorite movie?

A: I still enjoy "The Sound of Music". I also love "Terry", a touching movie where Terry Fox, who after being diagnosed with osteosarcoma with a poor prognosis, ran across Canada with prosthesis to support patients with cancer.

Q: What do you enjoy doing in your spare time?

A: I love spending time with my family and maximizing time for travel to see my kids. I also enjoy walking around campus with my wife.

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

A: First and most importantly, stick to your core values. As physicians, you can be the most skilled and knowledgeable upon graduation, but without values and professionalism, you won't make it. Second, get advice from people you trust and role models in the institution. They will advise you and help you develop your career. Third, be persistent and never give up. Even if people try putting you down or discouraging you, or you feel frustrated with your team, take every challenge as an opportunity. That is how you succeed.



RESEARCH: AN UNDERRATED INVESTMENT

Rashed Ghandour, PGY5 Urology Resident

I always disliked research, or so I thought. Reading a scientific paper in medical school involved skipping to the results and conclusions, ignoring the design and methodology. I read the abstracts and simply memorized the numbers I needed. Back then, I saw research as a much less exciting way to preface my training in surgery. I saw it as a boring experience where months, or even years, are “wasted” as a final resort for those with a gap year.

During my surgical residency, I had the opportunity to spend a year of research at Columbia University. Weeks before my departure, I was terrified! Even my title sounded foreign to me! What does a “post-doctoral research fellow” do? I had no idea where to start, what to expect, how to perform, and above all, what it takes to impress as a researcher! Nonetheless, I had faith that the background and work ethic instilled by my AUB education had prepared me for the task at hand.

To my surprise, my year at Columbia was among the most fruitful of my life. This “gap” year of research, which many people consider to be lost time, was actually a gain far beyond what I could have imagined. I now consider research to be a formative and almost irreplaceable experience for medical students. Throughout my participation in research, I became well read. I was also exposed to many doctors and students from different cultural, religious, academic, and political backgrounds. I learned how to better tolerate and adapt to my surroundings. Most importantly, taking a step back from the clinic and looking at medicine through a researcher’s lens reignited my passion for clinical medicine and equipped me with a better understanding of it. To me, research is no longer a means to an end, but rather an end in and of itself.

What medical students don’t often know is that the journey of research might offer a lot more than papers and publications. It can offer the opportunity to shape and refine one’s paramedical personality, recreate one’s medical career, and make contacts that will be the keys to opening the doors of success.

بين الواقع والأمل: رحلة في مخيلة تلميذ

محمد شحرور، تلميذ سنة أولى في كلية الطب

لا يرتبط توقف الضغط النفسي الذي يشعر به تلميذ الطب في الجامعة الأميركية في بيروت بالكلم الهائل من المعلومات التي يتلقاها في فترة قصيرة فقط، بل هو يرتبط بشكل وثيق بصعوبة الإختبارات وما تتطلبه من تفكير وتحليل منطقي، إلا أن هذا الأمر متوقع من أي كلية طب مرموقة في العالم. ولولا هذه الشروط، لما كان الدخول إلى كلية الطب في هذه الجامعة يتطلب معدلات عالية في الإمتحانات العالمية إضافة إلى النجاح في تقييم للشخصية التي يخضع لها من خلال المقابلات و النشاطات غير الأكاديمية. إلا أن ما يميّز ما يعيشه الطالب هنا هو ذلك الضغط النفسي الناتج عن وضع البلد الأمني والإقتصادي غير المستقر.

يجلس الطالب في مكتبة صعب الطبية ليدرس عن عضلات القلب في كتاب التشريح، فيخفق قلبه تارةً عندما يتذكر اقتراب موعد الإمتحان و تارةً عندما تراوده افكار عمّا يمكن ان يحصل بين لحظةٍ و اخرى في اي مدينة لبنانية من دمار على اثر انفجار او اغتيال، او حتى حرب جديدة من الممكن أن تشتعل فجأة في بلده. فقد اصبحت الانفجارات طقساً من الطقوس الحتمية، تزورنا كما الأعياد سنوياً، بل حتى موسمياً. مرّة في البقاع و اخرى في الشمال. مرّة في وسط بيروت، و اخرى في ضاحيتها. لا تستثني احداً.

يغلق الطالب الفصل المتعلق بالقلب، ليفتح ذاك الذي يشرح عن الدماغ. كل جزء من الدماغ مسؤول عن عمل معين. يقرأ عن ذاك الذي يقوم بالأعمال الحسابية، فيتذكر ان يحسب ما عليه من اقساط للمصرف الذي اقترض منه المال ليدفع الأقساط الجامعية المترتبة عليه. ثم تراوده بعض الأسئلة عن القرارات التي اتخذها لكي يصل الى حيث وصل. هل كان عليه ان يدفع هذه المبالغ الطائلة لكي يصبح طبيباً؟ يتذكر البعد الإنساني الذي دفعه لأخذ هكذا قرار. يريد ان يساهم في شفاء المرضى و تخفيف عذاباتهم. يعود الى الواقعية فيسأل نفسه كيف سيدفع الديون وما ترتب عليها من فوائد للمصرف. ها هم الأطباء المتخرجون في المكتبة معه، يبحثون عن فرص العمل في دول بعيدة بعد ان فقدوا الأمل من ايجادها في بلدهم.

يغلق الطالب الكتاب مجدداً، ليفتح الجريدة بحثاً عن خبر يعيد له بعض الأمل. يقرأ انه اصبح للبنان، اخيراً، و بعد شغور طويل، رئيساً للجمهورية. تأخذه مخيلته بعيداً. سيعمل الرئيس على إعادة الإستقرار الأمني الى البلاد. ستعود المرافق العامة للعمل بالطاقة القصوى. ستتطور الأنظمة الصحية المتبعة وستتحسن احوال الأطباء و المرضى. سيصبح لبنان بلد السياحة الطبية الأول في المنطقة والعالم، يقصده المرضى من كل حدبٍ وصوب، فأطبائوه ذوو معارف ومهارات وخبرات عالية، ومستشفياته تحتوي على اكثر التجهيزات تطوراً وأبرز التقنيات حديثة..

ببسمه خجولة على وجهه، يعود ليفتح كتاب التشريح، يدرس لإمتحانه القريب، و في قلبه امل بمستقبل افضل للجميع..

CONVERSION THERAPY: DOES IT REALLY WORK?

Ahmad Abou Mohammad, Med III

Conversion therapy, reparative therapy, or Sexual Orientation Change Efforts (SOCE), describe the various approaches aimed at changing the sexual orientation of individuals that identify as Lesbian, Gay, or Bisexual (LGB). Psychiatrists, psychologists, and religious figures have been the major providers of such practices. Conversion therapy is based on the assumption that homosexuality as a sexual orientation is pathologic. In December of 1973, the American Psychiatric Association voted to remove homosexuality as an abnormal diagnostic category from the Diagnostic and Statistical Manual (DSM). Despite this motion, reparative therapy remains prevalent to this day.

The majority of the literature examining the effectiveness of post-conversion therapy has demonstrated little to no success. In fact, an overwhelming amount of empirical evidence documents the damage induced by conversion therapy, which includes psychological, spiritual, social and sexual harm. In spite of the general understanding that conversion therapy may be harmful, many licensed and unlicensed therapists continue to practice it in their clinics.

The failure of conversion therapy may often lead to a psychological process known as "disillusionment" which is characterized by severe and overwhelming conflict between an individual's emotions, behaviors, and cognition. This arises when, despite significant effort, the therapy is unsuccessful in changing one's sexual orientation. The patient begins to have feelings of guilt and self-hatred, which can spiral into increased frustration and deleterious self-harmful behavior, such as substance abuse and suicide attempts. Others may react to post-conversion therapy failure with increased anxiety, apathy, compulsive work behavior, or depression. In addition, the quality of relationships is impacted as individuals may refrain from emotional intimacy and sexual activity.

As long as homosexuality continues to be viewed as a disease that can be treated, homophobic beliefs and behaviors will continue to perpetuate in society. It is crucial to understand the implications of medical authority as a source of validity. If homophobic practices within the medical field such as conversion therapy remain prevalent, discrimination against homosexuals' rights to marriage and healthcare will remain justified. Therefore, conversion therapy is truly a sensitive issue that defines the framework of this disadvantaged community.

The practice of conversion therapy is based on homophobic beliefs that contradict overwhelming empirical data. Homosexuality is now recognized as a normal sexual orientation by scientific authorities such as the American Psychiatric Association, Lebanese Psychiatric Society and the Lebanese Psychological Association. Despite the Lebanese Psychiatric Society's opposition to the classification of homosexuality as a disorder in July of 2013, conversion therapy continues to be heavily practiced in Lebanon. In light of the evidence establishing that conversion therapy is ineffective and damaging, a recommended change in the legislation that would prohibit this practice needs to be made.



Have you considered a medical career?

Illustration by: Alaeddine El Alayli

OUT LOUD!



AS A MEDICAL PRACTITIONER, SHOULD CONVERSION THERAPY REMAIN A PERSONAL CHOICE OR SHOULD IT BE BANNED?

A



“As a medical practitioner, we are driven to practice Evidence Based Medicine. If there is proof of harm, then I would recommend against it. However, if studies show benefits, I would keep it as an option for individuals.”

Katia Genadry, Med IV

A

“There is currently no evidence that any form of conversion therapy works. Any potentially harmful procedure should be banned. On the other hand - if it is harmless - we have a duty to discourage the patient from going for it, but we shouldn't go as far as banning it.”

Samer Nouredine, Med III



WOMEN'S SEXUAL HEALTH IN LABOR

Narjes Jaafar, *Med II*

Sexuality is an important factor that affects the human life and general well-being. It reflects experienced feelings which are expressed in language, thoughts, beliefs, behaviors, values, practices, and relationships. Sexual health is part of the overall individual health, as disrupted sexual health disturbs the overall wellbeing, quality of life, and relationships as well (El Kak et al, 2004).

In the traditional societies of the Middle East and North Africa (MENA) region, the UN Development Program depends on the measure of gender empowerment to rank us next to last, behind sub-Saharan Africa (HDR, 2015). Sexual health knowledge and awareness lags in Lebanon both at the societal and the structural levels, whether through the absence of national sexual education programs or in the non-focused healthcare practices.

Sexually transmitted diseases (STDs) are considered to be only transmitted by 'dirty' sexual affairs. This social stigma stands in the way of women seeking necessary medical attention. Women become more vulnerable and less likely to get educated about contraceptive practices, sexually transmitted diseases, safe sexual practices, and preventive measures, such as HPV vaccination.



Sexual taboos are amongst the barriers that keep women from testing their Human Immunodeficiency Virus (HIV) status. Other societal barriers include perceiving pre-marital sex as a taboo, constant surveillance over women's sexuality, and HIV being sexually transmitted (Clark et al, 2016). The HIV epidemic in the MENA region has become of increasing concern to the Global HIV epidemic, as infections have tripled. The AIDS-related deaths have increased by 66% in MENA, compared to a 35% decrease worldwide between 2005 and 2013 (UNAIDS, 2014b). While the primary mode of transmission is heterosexual, reported incident cases are disproportionately among men (Abu-Raddad et al, 2010). However, the societal stigma of women's sexuality contributes to the under-reporting and under-detection of HIV incidence of women in Lebanon.

As far as sexually transmitted diseases are concerned, a failure to stand up for a woman's sexual health is a failure to stand for her partner(s)'s sexual health as well. In fact, sexual education should start in schools even before it takes place in clinics. Such an education will be a mere translation of our efforts to empower women to have healthy relationships, combat possible sexually transmitted diseases, and avoid unintended pregnancies.

Rather than shielding and shaming women's sexuality, we should look at any woman as a person with equal rights to those of a man and her sexuality as inseparable from her being. We, as healthcare providers, have a duty to promote sexual education and sexual equality in an effort to promote a healthier society. Sexual health is not only a personal battle, but it is a medical and social fight that involves us all.

Clark, K. A. (2016). "Women are not perceived as sexual beings"

El-Kak, F., et al. (2004). *Gender and sexual health in clinical practice in Lebanon. International Journal of Gynecology & Obstetrics*, 87(3), 260-266.

Abu-Raddad, et al. *Epidemiology of HIV infection in the Middle East and North Africa. Aids*, 24, S5-S23.

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WHAT DO YOU SUGGEST TO HELP INCREASE STD TESTING (HIV INCLUDED) AMONG WOMEN?

A



“ I think that implementing Sex-Ed in schools is the best way to help increase STD testing among women. Educating women early on about the benefits of regular STD testing plays a big role in decreasing the probability of infection. ”

Youssef Annous, Med II

“ We should train doctors, especially Obgyn, to take the initiative in asking about their patients' sexual health and worries. The skill of sexual history taking is the first step towards better diagnosis and testing. ”

Wadad Alameh, Med II



A

DAVINCI'S SURGICAL ROBOT: THE NEW KID ON THE BLOCK

Ragheed Saoud, PGY5 Urology Resident

It's Thursday morning, 7:30 a.m. Your scrub suit is on, and your facemask is tightened. You step foot into operating room number 4. On any other Thursday, you would expect to find surgeons and nurses swarming anxiously around a patient lying flat in the middle of the room. In June 2013, the advancement in healthcare at AUBMC shifted with a new gadget that has been installed in room 4. More accurately, a new monster of a machine is now the highlight of minimally invasive surgery at AUBMC. Room 4 has become home to Intuitive Surgical's most renowned creation: the 1.5 million dollar DaVinci Surgical Robotic System. This behemoth of a machine takes center stage, surrounding the patient with its four spider-like arms, ready to dive deep into the patient's body through keyhole-sized openings. At the same time, an operator sits comfortably at the console controlling it with pedals and joysticks, looking more like a Nascar driver than an old-school surgeon. Scalpels are obsolete, retractors unheard of.

Since its inception in 1999, the DaVinci robot has taken the surgical world by storm. Its dramatic growth has been unprecedented, creating an unexpected paradigm shift in the approach to surgical therapy. In the United States alone, Intuitive Surgical has increased its sales by 400 percent over 4 years, selling more than 1400 robots nationwide. At AUB, the utilization of the robot has exponentially increased since 2013, especially in the field of urology.

But why all this hype? What is so attractive about this machine? Is it simply surgeons' preference or are patients invariably attracted to high-end technology? The answer is both. For surgeons who've always had to stand and operate for hours at the patient's bedside, this is a dream come true. For the first time, the surgeon has the luxury of sitting comfortably at the console, executing the finest movements in snug spaces. The strikingly vivid views provided by the robot's high definition camera, even in the darkest cavities of the human interior, are quite magnificent. Patients, on the other hand, are advocates of self-interest. As long as scars don't show, the pain is tolerable, operative outcomes are superb, and hospital stay is shorter. Many patients don't mind paying extra for 'cutting edge' robotic technology. The formula of its success is clear and balanced.

What does the future hold for robotic surgery? Practically speaking, the ship has sailed, and newly trained surgeons will have to keep up with this rapidly evolving equipment. At this point, shunning technological advancements is futile: the robot has proven its superior outcomes and advantages, and is already utilized at top institutions around the world. At AUBMC, the robotic program remains young and limited, but it is moving forward. Programs should expand to involve more specialties, including thoracic surgery and otolaryngology. A reduction in associated cost is cardinal, for it would encourage a larger patient base to opt for this type of surgery. Moreover, on an educational level, surgical residents must be encouraged to take advantage of the presence of a second console and actively engage in learning how to maneuver this new technology, in order to create a generation of technologically proficient masters in robotic surgery.

Makary MA. 2012. The all-American robot. In: Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care. New York, NY: Blooms-bury Press.



OUT LOUD!



HOW DID THE INTRODUCTION OF THE DAVINCI ROBOT INFLUENCE YOUR PRACTICE AT AUBMC?

A



“ Robotic surgery made a significant change in our approach to the treatment of localized prostate cancer and small renal masses. Surgeons should not be intimidated by it but rather embrace it as the technology of the future.”

Mohammad Bulbul, MD

A

“ I have performed more Robotic Prostatectomy procedures than Open Radical Prostatectomies in the past year, and have been very pleased with the ease of performing nerve sparing using Robotics, enabling men to regain potency faster postoperatively.”

Raja B. Khauli, MD





BEHIND THE WHITE COAT

What is a hobby you enjoy outside medicine?

Dr. Souha Kanj
Sharara:
swimming

Dr. Kamal Badr:
guitar playing

Dr. Samia Khoury:
belly dancing

Dr. Alaa Sharara:
guitar playing

Dr. Ramzi Sabra:
playing organ
pipe

Dr. Mona Nasrallah:
reflecting

Dr. Rana Sharara:
traveling

Dr. Zeina Kanafani:
singing

Dr. Ghassan Hamadeh:
programming