Lessons in a Loss: A Journey Through Friendship, Cancer, and Medical School

Nathaniel B. Verhagen, BS

During my transition to middle school, my friend Andrew was diagnosed with brain cancer. I recall my parents reassuring me that he would be receiving world-class care at the Children's Hospital of Wisconsin. Ten-year-old kids aren't supposed to die from cancer I thought, and thankfully, he didn't. However, the gauntlet of surgery and chemotherapy greatly weakened Andrew. The star athlete, student, and friend became restricted by his debilitating illness, but his optimism and carefree attitude always seemed untouched.

Andrew's mom recently shared a story about when he finished his first round of chemotherapy that perfectly captures his positive demeanor. She described the great joy in the hospital on the day that Andrew rang the bell, signifying the end of his chemotherapy. However, this moment of relief was quickly replaced by fear as Andrew later developed pneumonia. Andrew's doctors were concerned that he may not make it through the infection. Visibly upset and stricken with fear, Andrew's dad entered the hospital room to check on him. This was when Andrew—in his witty, nonchalant manner that everyone loved—asked, "Dad are you really crying? I am going to be fine." And he was.

As I went on to live out a normal middle and high school experience, Andrew's cancer recurred, and he was in and out of treatment. His illness kept him from enjoying the milestones kids our age were supposed to, like attending high school graduation. When it came time for me to go off to college, he was pursuing a hopeful clinical trial. We both had dreams of a brighter future.

> While the world of medicine is unbelievably interesting and engaging, it is only part of our identity. We are sons, mothers, friends, authors, artists, and, above all, humans.

This year, I started medical school at the same institution where Andrew began his cancer journey nearly 12 years ago. Every time I enter Children's Hospital, memories of first visiting Andrew's hospital room flood my mind. When Andrew was first diagnosed, a group of our friends went to visit him in the hospital. We were all given visitor bracelets and went up to his room to find him smiling in his hospital bed. My initial worry of seeing Andrew for the first time since he was diagnosed disintegrated immediately. We began doing what you might expect middle school boys to do--recklessly tossing a ball around his hospital room. His baseball prowess continued to shine through as the ball zipped around the room; however, we were all unable to comprehend the hardship he was enduring. Thinking of these moments with Andrew have added so much purpose to my medical education. He has fueled my passion for cancer research, and during a hectic exam week, the thought of Andrew adds an obvious relevance to my field of study and the patients I hope to care for.

Only when I began learning how to save a life, Andrew finally lost his. After over 10 years of highs and lows, his journey concluded. He had endured two brain surgeries, six port placements, lost his hair six different times, took over 100,000 pills, and boarded 62 flights for a clinical trial in a span of 2 years, while also managing to attend college for five semesters. To this day, I do not think he complained once.

This summer, I was fortunate to conduct research through the Medical College of Wisconsin's Medical Student Summer Research

continued on page 3

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Do Internal Medicine Hospitalists and Advanced Practice Providers Desire Training in Diagnostic Point- Of- Care Ultrasound? A Cross Sectional Survey

Dear Editor:

Point-of-care ultrasonography (POCUS), especially that of heart, lungs, deep vein thrombosis, volume status, and free fluid assessments, is a great adjunct to bedside clinical examination for inpatient medical care. Its diagnostic accuracy, reduced time to diagnosis, prognostic significance, and favorable impact on physician-patient interactions is reverberating in our industry.[1] In recent studies, emergency department POCUS led to a change of diagnosis in 30% of cases and change in management in 89% of life-threatening situations.[2] In critical care and anesthesia cases, it changed diagnosis and management in 41% to 51% and 43% to 82%, respectively.[3] Although established in the specialties of emergency, critical care, and anesthesia, internal medicine is relatively new to POCUS.[4] And now there seems to be a widening knowledge gap between faculty and trainees, as undergraduate and graduate medical education programs incorporate POCUS training into their curricula.

In November 2022, we conducted a cross sectional survey to assess the level of exposure, perceptions, and interest towards POCUS training. An anonymous 13-question Qualtrics survey was sent to all Medical College of Wisconsin faculty and advanced practice professionals (APP) in the divisions of Hospital and Perioperative Medicine.

A total of 59 faculty and APPs completed the survey, with a response rate of 41% (60% were hospitalists; 40% were APPs). Thirty-three percent of respondents had more than 3 years of experience in their field. Around 24% of respondents had completed a POCUS training course: the majority had in-person hands-on training, and 2 had full certification. Sixty-six percent of the POCUS-trained faculty had less than 3 years' experience performing POCUS, whereas 33% had more than 3 years' experience. Seventeen percent reported using POCUS in routine clinical practice; 77% perceived benefit to diagnostic POCUS in clinical practice and teaching learners. Most respondents highlighted the importance of POCUS as a bedside tool, especially in volume status assessment. Eighty percent of respondents were interested and willing to commit time up to 40 hours for a longitudinal training program with an online precourse, a hands-on workshop, and then a longitudinal mentored portfolio creation for practice.

This survey highlights the glaring knowledge gap among faculty and the need for a well-structured longitudinal training program. A focused curriculum, Faculty for longitudinal assessment, image archiving, quality assessment, and devices are key for its success.[4,5] Our future efforts will be to secure support from leadership and funding and partnering with local physician organizations.

—Anu Taylor, MD; Abhilash Koratala, MD; Pinky Jha, MD

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Lessons in a Loss

continued from page 7

Program. My research focused on optimizing preoperative care for cancer patients undergoing surgery. While I had always been interested in cancer research, my work took on a whole new meaning. Starting research early in the morning suddenly felt less early and there was an overflow of motivation to continue working into the evening. Dedicating my summer to this research was so abundantly meaningful when the patients I hoped to help became so familiar.

At times I wish I could harness my 10-year-old naivety again; 23-year-olds are not supposed to die from cancer. Only now I know too well they can. Andrew is dearly missed, and as I reflect on his arduous journey, below are a few observations I wish to share and will carry with me throughout my medical career.

First, appreciate the little things in life. The last time I spoke to Andrew, he explained how difficult it was for him to see a world so full of complaints. This is as good of a reason as any to find the positives—no matter how small—in every moment.

Second, we must hold tightly to the things in life we value most. While the world of medicine is unbelievably interesting and engaging, it is only part of our identity. We are sons, mothers, friends, authors, artists, and, above all, humans. Finally, adversity is inevitable throughout our lives, so I will conclude with the motto Andrew found strength in throughout his journey: Be courageous, stay strong, keep faith.

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