On June 8, 2017, The Liaison Committee on Medical Education (LCME) determined to grant UCR School of Medicine full accreditation for a five-year term. The accreditation milestone came on the eve to the first graduation ceremony and Hippocratic Oath.

The LCME is recognized by the U.S. Department of Education as the accrediting body for medical education programs leading to the MD degree. In determining a medical school’s eligibility for accreditation, the LCME reviews its compliance with the 12 LCME standards, which cover accreditation requirements for curriculum, student services and well-being, faculty, educational resources and policies.

The full accreditation marks the culmination of the three-step process that began with preliminary accreditation back in 2012, which allowed the school to enroll its first class of students. Followed by the provisional (“Accredit” continued from opposite) accreditation in June 2015 and lastly, the full accreditation process.

LCME accreditation is assurance that medical education programs meet established standards for preparing medical students in educational competencies that are appropriate for their next stage of training. It also advances continuous institutional and programmatic quality improvement.

So, we move forward continuing to do what we do best every day: helping patients heal, teaching and learning, and advancing knowledge through discovery. The work we do at UCR School of Medicine is imperative and we will continue to do it well.

I would like to take this opportunity to express my heartfelt thanks and appreciation to all of the medical students who participated in the LCME full accreditation process.
Well, several of us—med students, staff, and other volunteers—took on some high school kids for the good part of a day. About 75 high school students, per session, visited our SOM campus to learn about and experience all that our medical school has to offer. Organized by the amazing Jericha Viduya, Wesley Lockhart, Chris Miller, and Tammy Clawson, the group came as part of the National Youth Leadership Forum on Medicine. They arrived at about 9 AM all the way from UCLA and received a welcoming speech from Dr. Schiller. Then, they got right into it by rotating through different stations consisting of vitals, PBL, ultrasound, splinting and bandaging, EKG scenario, and a tour. There was also a panel where they got all their questions answered. How do you prep for the board exams? What should I major in? What do you recommend doing before starting medical school? So many questions. Some of which I had when I was thinking about medical school.

The experience got me thinking though, as Dr. Schiller explained the admissions process and the qualities they look for in students granted admission. We all have different paths of getting here and it may be easy to forget all the hard work that got us here. Leading high school kids around, trying to teach them vitals in 30 minutes, and

("Summer" continues on p4)

Population Survey

Students and staff were kind enough to share their answers to this issue’s question: Which UCR SOM staff or faculty member would you want to go on vacation with?

“Dr Gavan. She’d be fun to have conversations with and shop with. She seems down to earth so she wouldn’t be excessively active. She’d be chill.”
-Karen Cicrey, MS2

“I’d pick Tracy or Dr Ballou. Tracy’s really down to earth and we’d also have fun conversations. She would also be willing to try different foods. Ballou is kind of the same, and he’d have jokes to add to the trip.”
-Mauricio Bonilla, MS2

“I’d go with Tammy because she’s young, hip, and she gyms.”
-Patty Guan, MS4

“Dr Cao. He brings snacks. He brings good quality wheat thins.”
-Lawrence Liu, MS3

“Chris Miller. I feel like he would have endless jokes and positivity. I asked him the other day if ever had a bad day. He said ‘nope’ and I was like ‘me either’.”
-Gerardo Lopez, MS3
The past year has been a notable and historical eruption of political debate and opinions, all of which have inspired a great deal of think pieces. But maybe none more so than the idea of political correctness. It is a concept that is discussed on both ends of the political spectrum, and probably at every point in between as well. It is discussed so much, in fact, that the very idea of being “PC” has become somewhat diluted and unpleasant. Like a soda which has become watery and tasteless after having all of its ice melt—no longer palpable or desirable.

Let us allow ourselves to be cliché for a moment and define the term. Political correctness is “the avoidance of forms of expression or action that are perceived to exclude, marginalize, or insult groups of people who are socially disadvantaged or discriminated against.” This does not seem so bad, does it?

But many people agree that political correctness has been taken too far. We are American. We are unabashed and we are unapologetic. Why should we slow down to make sure everyone’s feelings don’t get hurt?

But maybe it is this very mindset that is actually challenging our ideals as Americans. For we are a nation of diverse cultures and peoples—built by immigrants, grown through the innovation of ideas and practices. We relish opinions and critique and some say that by increasing this demand for a more P.C. society, we are stifling the ability to grow through stern evaluation and constructive criticism. And that very well may be true in some cases.

But political correctness should not be a problem for those who are expressing valid and constructive opinions. Such dialogue will always be taken in stride, regardless of whether we decide to be more inclusive of others or not. Political correctness, in practice, is really only a problem for those who feel that they can no longer get away with their thinly veiled prejudices without being called out on it. We will always have our free speech, but let us not waste it with bigotry and racial stereotypes.

It is especially important for individuals such as ourselves here at the UCR School of Medicine to keep this in mind. We have an incredible responsibility to our historically marginalized and underserved community to be understanding and endlessly inclusive, especially when it comes to something as sacred as health. For many of our patients, they are in the most vulnerable moments of their lives. Instead of wasting time politicizing a concept that is as simple as the first rule they teach in kindergarten—treat others as you would like to be treated—let us just act the way we should, as dignifiers and protectors of human life. Let us take the political part out of the correctness we should be practicing.—
“Your Hands Are God”
Poem by: Paul E. Kaloostian MD, FAANS, FACS
Neurosurgery, UCR School of Medicine

The kindest man as he was known
Septegenarian, Hispanic, he lived life with no loan.
Three daughters so loving, a wife full of prayer
Senor was now gasping for his final breaths of air.

Residing at a care center, his needs being fulfilled
Sudden unexpected explosion, the brain’s oil was drilled.
Going into coma, no movement even to pain
Onto the ambulance, is the hospital ride in vain?

Picture of the head shows a massive intracerebral hemorrhage
Compression of midline structures, the brainstem is disparaged.
Time is of the essence, every second determining brain cell function
Is there a chance of salvaging his life without dysfunction?

I spoke to his daughters, river of tears miles long
Pleadéd with his wife, an old soul but now not so strong
I offered them a chance, though slim and frought with danger
A longshot, trip to the moon, at that moment I was no stranger.

They grabbed my arms, they cried on my shoulders
They prayed while hugging me, asked God to have me move boulders.
They kissed my hands, blessing them with a symbolic reverential spirit
I rushed him to the operating room, I did not fear it.

Within minutes his head was prepped, his hair had been shaved
Incision was marked, trauma question mark was paved.
Blade to the skin, dissection of the skin flap to forehead was accomplished
Four burr holes were drilled, large piece of his skull was admonished.

Covering of his brain was so tense with pressure
Opened this layer, called the dura mater.
Brain swelled out, you could almost hear the cells chatter
“We are free, we are alive, a new chance to climb the ladder.”

Post operatively within hours el senor opens his eyes
Family at bedside, they cling to me with surprise.
Tears of joy, Tears of hope, Tears of rejoice fill the room
“One hands are God” they say to me, felt like a witch flying high on a broom.

That night I lay in bed, my wife and dogs in a deep sleep
I think about the kind words from the family, not cheap.
I made a difference in this world, I saved this man’s life
Those years of training and sleepless nights proved valuable,
with the help of a knife.—

Culture: A Determinant of Health Outcomes
By: Cynthia C Ogubuike, MS2

The cultures that we practice have just as much impact on the health of the patients as the science we learn in the classroom. I have found that in many of our health facilities, there is a culture of superiority, judgment and often times unrealistic expectations from healthcare workers to patients. Our responses and receptiveness to patient conditions is a huge determinant of how well our healthcare system ultimately works. Very little care is taken to understand the background and other influential factors that determine the conditions our patients present with. We sometimes portray the feeling that our patients are inattentive, unreceptive, and sometimes irresponsible with regards to managing their health. On multiple occasions, I have witnessed a physician discredit a patient’s complaint before walking through the door because merely looking at the charts or talking to a colleague revealed blemishes on the medical or social history of the patient. Taking the perceptive that the patient is automatically at fault for not having his/her blood sugar under control because of lack of discipline and adherence to a diet and exercise regimen without putting into consideration compounding variables like their financial and environmental living situation is one of the easiest ways to unintentionally assume a judgmental tone during the actual physician patient encounter. This becomes a major issue in underserved areas where the social and economic status of our patients are interwoven with their health. Patients can often see through the condescension and either withdraw into themselves, resist any assistance, request different health care professionals or worse, develop negative impressions about healthcare workers in general.—

(...“Summer” continued from p2)
seeing their excitement really reminded me of that path to getting here. Summer, in terms of school years, is often a time for a fresh start. So I hope, whatever you may be doing, that you take some time to reflect and think about this particular moment. Easily forgotten but an essential thing to do to grow and continue learning, not just as a student, but as a person. Because medicine, as we are often reminded here at UCR, requires a lot more humanity than people think. In any case, here’s to the summer—hope it’s a good one!—
Other than being the title of an amazing TV show, scrubs are utilized as a sort of medical uniform. In a busy hospital where patients seek help, doctors try to help and medical students try to look busy, scrubs are worn to avoid the hassle of trying in the morning. But you have to try and stand out; try and individualize your look. You might ask, “can I fashion cut-offs with my scrub bottoms?” or “can I fray some fashionable holes over the knees?” All reasonable and creative ideas though unfortunately, patients and colleagues might frown upon your impeccable style. But have some hope! We came upon some lucky people who made those scrubs their own. And we look to these shining icons for advice.

Elias Fanous, MS3
Elias: “Biceps in Scrubs”
Look at those bulging muscles. He allows for his scrubs top to be juuuust tight enough to grab your attention, but the sleeves cover enough to leave you wondering. You might forget his name, but will you forget his arms? Unfortunately, the drawback to this look is holding that position throughout your shift so your attending and resident won’t forget you when they write your evaluations.

Tri Tran, MS3
Tri: “Propriety in Scrubs”
Ahhh, the classic white coat over scrubs look. Unfortunately, this look is the hardest to individualize, but it’s easy when your scrub machine dispenses differing shades of blue for your top and bottom. Nothing says that you clean bodily fluid off your scrubs than an over-laundered scrub top. Sure, it’s not on purpose, but short of emblazoning your name on the back of your $70 white coat, accidentally mismatched scrubs is your best bet. Pair that with your hands in your pocket and an award winning smile and you have a winner.

Veronica Scott, MS3
Veronica: “Tree-Hugger in Scrubs”
Despite the slight embarrassment shining through her face, Veronica has embodied the love for her environment in this look. Look how happy she is. Though the first thing you might notice is her reluctance in fully hugging the tree, look harder and notice that both of her feet are pointing at the tree. That’s true love. This look is much harder to pull off due to the limited time she spends outside, but she’s looking into investing in fake trees she can lug around the nursery with her. No one can forget Veronica.

Josh Fan, MS3
Josh: “Wilderness in Scrubs”
Stunning. In a hospital where the windows are smeared with bird poop, it’s doubly amazing when your look can be fashionable and functional. The glasses to distract the birds, the bag to hold your bird poop cleaning supplies, and the phone to answer your resident’s beck and call. Unfortunately, the last item isn’t used as much one may think, but it’s part of playing the game. But we also can’t forget Josh’s personality shining through this look. Stay wild, Josh. Stay wild.
“It's Just Ok”  
By: Sumedha Sinha, MS3

They say clerkship is “no more time for milk and cookies.” You think to yourself hmm. Why can’t I have milk and cookies? After all, there are always milk and cookies available in the hospital cafeterias. Before I start, I have yet to have milk and cookies together but have had them separately during my clerkship. Still counts! The cookie was even offered by a resident. With that my friends, it’s time to talk about the most serious topic in the years of clerkship.

Hospital cafeteria food. Yep. Let it sink in for a few minutes. What pops up in your head? Is it associated with the word cafeteria? Well you’re correct! Didn’t think it was quiz but you’d be wrong how random passing questions can be quizzes of your understanding. Before we being in this article, I would like to say to say thank you to all the hard working cafeteria people. Without cafeteria food, a lot of people will go hungry, which will equal to hangry people within a couple more hours. Hangry attendings and residents...someone better move out the way. So thank you for letting displacement not be a part of my daily life. A fair warning. This is the first time in yours truly, the (“Ok” continues on p8)

“The Underserved: The Medically Indigent in the Inland Empire”  
By: Steven Hough

The Inland Empire is made up of Riverside County and San Bernardino County in Southern California. A unique demographic in comparison to the rest of the country, an estimated 250,000 undocumented residents live in the region. That is an estimated 6.5% of the population. Of this subpopulation, 31% live below the poverty line. As undocumented residents, these community members are restricted from accessing ACA or AHCA insurance. The lack in coverage leaves many of these residents without regular access to health care. In order to address the needs of this disenfranchised group, the medical communities in the Inland Empire offer vital services, like free clinics, to ease the burden of “safety-net hospitals” and allow greater opportunity for those who lack health care to obtain basic health support. In a recent visit to the San Bernardino Free Clinic, I was able to personally meet a patient who had immigrated to the United States, but was unable to find health care access due to his undocumented status. A past kidney transplant had left the patient on a multitude of medications and required regular visits with a nephrologist. Unfortunately, he was unable to obtain health insurance and was only recently able to find a clinic that he could afford to be seen in. It had been almost a year since he had seen a nephrologist; a startling fact since his medications required dose checks and obviously kidney function testing regularly. By the end of the visit, the patient was scheduled to meet with a nephrologist who worked with the clinic, however, we were unsure about the time it would take to establish an appointment and the closest clinic where we were able to offer the services were in Orange County, a substantial drive for our patient.

This patient is just one of many, law-abiding, tax paying residents that are left unrepresented and without a political or legal voice in health care reform. It is therefore necessary for others working in the health care industry to speak for those who cannot, bringing to light (“Underserved” continues on p7)
where are you from?
Born in Menlo Park (SF Bay Area), then moved to Davis/Sacramento area for college, then stayed to raise my family.

what brought you to ucr school of medicine?
I was intrigued by the newness of the school and I felt that I would interact with students more closely. I was also very impressed with those I interviewed with.

how do you like riverside so far?
LOVE IT!! The area reminds me of the SF Bay Area long ago when it wasn't “Silicon Valley”, and I love everyone I work with.

what are your goals for student affairs at UCR school of medicine?
To make it the best school for medical students in the country of course! Hopefully we in student affairs can continue to grow our support for students to make their four year journey even more meaningful, enriching, and inspiring.

why do you enjoy working in student affairs?
First, I love working with students (I used to teach Micro). Second, I love to solve problems and help others. Third, medical students have needs and sometimes problems. It’s a perfect fit!

favorite book?
Whatever I’m reading at the time, usually fiction. It runs the gamut from Patricia Cornwall to Alexandre Dumas.

what is the greatest adventure or vacation that you’ve ever had?
Hopefully yet to come! However, I used to spend summers sailing (and racing) with my Dad on Lake Michigan. Those were wonderful days!—

work with the community.
Working with the community is different than working within city limits. In order to truly understand the area in which you work, exposure to different types of clinics, specialties, and hospitals are key. No one location will fully show the diversity in any population. Getting into the community and becoming familiar with the common threads of disparity is the first step in understanding the community you’re working with and offering productive assistance.

learn about access.
Without proper knowledge of health care access, it is impossible to help the patients who come to you for help. Exposing yourself to prescription drug discount plans, knowing where the local free clinics are located, and understanding (at least minimally) how the local public health / social work system works will help you be able to connect your patients with the proper resources to keep them as healthy as possible.

become an advocate.
The patients who we interact with every time we go to clinic have a story behind them. More then their medical chart, each patient has an entire lifetime behind them. Being able to humanize patients has helped me in remembering why it is so important to be an advocate in and out of the exam room. Advocacy does not require publications, large events, or mastery of legislation. Instead, advocacy starts with understanding the big picture. Having enough local resources within your repertoire so that you can offer as much assistance to your patient as possible. It doesn’t take much to significantly change someone’s life.—
**“Untitled Public Health Article”**  
By: Spencer Wang, MS2  

The stigma of mental health is pervasive and has brought about interesting practices from mental health providers such as psychiatrists and psychologists that run cash practices to cater to patients who want to keep every possible trace of their mental health needs private. This brings in an interesting discussion about the stigma of mental health and the price some are willing to pay to keep these matters private and trace-free. Insurance companies have strict rules on psychiatric medication and these routes of seeking care are traceable through insurance accounts, credit card companies from payments, and shared/managed medical records from large organizations. This sort of service sought by patients speaks volumes to the stigma of seeking mental health care and will need to be further researched in order to elucidate more details on the stigma and social aspects of mental health care. These patients may have the cultural competency, knowledge, access, and financial resources of healthcare, but still are victims of the stigma on mental health. Therefore, they circumvent all traditional methods of seeking a mental health practitioner and opt to pay hefty fees to maintain secrecy.—

(...“Ok” continued from p6)

great food critic's history on The Scope, the article will not be flowing with praises or descriptions of food, but rather practical statements about hospital food. I’m going for the assessment and plan template, so bear with me.

**Practical statement #1.** Know the hours of the cafeteria and cafes, especially if you don’t have kind parents or supporting partners to pack your meals. I’m encouraging everyone to be familiar with the hours, even those of you who do things like meal prep on your own volition. You never know when you can be starving or need that one more extra cup of coffee.

**Practical statement #2.** Have snacks on you if you can & use your resources well to stack up on these said snacks... cough free food places...cough later on in the article.

**Practical statement #3.** The starving you is not a good look. Take time to eat something. No one expects you to be dying in the inside with no food for 12-13 hours. Your poor hypoglycemic brain won’t be able to tell the attending the answer to a simple question about something you have known since the 8th grade. Or worse, you can pass out. Thankfully, I’ve had the luck of having attendings and residents that have made sure I’ve eaten my lunch. That being said, make sure you give yourself the time to quickly go and eat when you’re just hanging out/have downtime.

**Practical statement #4.** Hunger makes anything taste good. Cafeteria food is cafeteria food even when some places are better. For the most part, the places I’ve eaten in (RCH, RUHS aka County, and San Antonio Regional Hospital), food is okay. Not the best thing or the worst thing. However, the buyers remorse can be higher in here, especially as you become more full. I had a turkey chili at Men’s Style Corner:

**5 Tips That Make You Look More Polished**  
By: Asbat Hasan, MS3

Iron your clothes! Clean, pressed clothes can completely change your look, so this is #1 for a reason. If you are always running late and have no time to iron in the morning, try doing it the night before or consider buying clothing chemically treated to resist wrinkles (i.e. non-iron shirts). For dress pants, opt for 100% wool pants or a wool-cotton blend, which rarely need to be ironed, rather than 100% cotton dress pants, which easily lose their shape and become wrinkled. They may cost a little more, but you get what you pay for.

Match the color and texture of your watch strap, belt, and dress shoes in professional attire for a more cohesive and put-together look. If your dress shoes are shiny and black, buy a dress belt that is also shiny and black. If your grainy chocolate brown dress shoes have a matte finish, buy a grainy chocolate brown dress belt with a matte finish. If you are channeling your inner Michael Jackson with sequin studded shoes, buy an equally glamorous sequin studded belt. You get the point. I would not recommend wearing brown belts with black shoes and vice versa, as black and brown colors often do not complement each other well in professional attire.

(“Polished” continues on p10)
RUHS this week. After my hunger pains subsided, I realized I wasn’t really into the food. I even contemplated throwing it away BUT (and a big but) so happy I didn’t do it. Later that day, I cleaned the left over turkey soup in less than 4 minutes. A new personal record for me. Think of it this way. MS3 year will also challenge you to break food eating personal records. How amazing is that!

**Practical statement #5.** Kind of piggybacking off the previous practical statement. Because hunger can make anything taste good, be aware of what you’re eating. This is not the time to stimulate your digestive system to the same amount as your brain is being challenged. If something looks off, don’t eat it. Wash your hands every time you’re going to eat including a protein bar. Lots of sick people in the hospital. Also, listen to the rustling, grapevine tales of food sickness from cafeteria food. Avoid those foods for at least a few weeks or all together. Yes, the last bit is over the top, but you never know. Plus, it’s good to have some flair in life. Why not swear an oath to never eat from the pasta salad bar that made an attending sick with vomiting and diarrhea?

**Practical statement #6a.** This one is inspired by our dear MS3, Magi Gabra. When asked how does the food taste at RCH, she exclaimed, “It’s great! It’s free, so it’s great!” Very important message. Know where you can get free food or snacks. For example, in the OB GYN clinic at RUHS, coffee lovers can rejoice at knowing there is a Keurig coffee machine. RCH has FREE food. If you’re at County and not stationed at RCH, you will have OB GYN lectures there. Food is still available to you at the cafeteria, and snacks are available in the back of class rooms. Stack up on a protein bar or two or three.

**#6b.** Be kind to the people you’re around. They’ll let you in on the free food secrets or even offer you food. I’m well versed in etiquette, so naturally it’s rude to refuse.

Alright my dear food adventures, please know you’re awesome. So clerkships better watch out your ability to kill it while enjoying some milk and cookies. I leave you with the quest to find the most amazing meal possible in the hospital cafeterias. So good that you dare rate it a 4 star on Yelp and with the full knowledge that all your Yelp Elite friends will also concur with your rating.—

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**Quotable**

“Can we just shelf the shelf exams this year?”
-Dr John Isaac, MS3

“Why is everyone getting so much diarrhea?”
-Deema Akari, MS3

“Moral of the story: don’t travel, buy electronics, or fall in love.”
-Ann Yufa, MS3

“Oh no, it’s summer?! I need to switch out my hand soap.”
-Khoa Nguyen, MS3
Medical Movie Review: “Extreme Measures”  
By: Rennie Burke, MS3  


How tempted would you be by a devil’s bargain, one that offered a cure for a horrifying disease that afflicts millions, but did so at the cost of innocent lives? That is the animating question of “Extreme Measures,” a now-forgotten 1990s medical thriller whose bland name belies an exciting movie that explores important ethical issues in an fun and suspenseful way. Hugh Grant, at the height of his power as a Hollywood heartthrob, stars as Dr. Guy Luthan, a New York City emergency room doctor who treats a patient suffering from baffling suite of deadly symptoms. Opposite Grant is Gene Hackman as Dr. Lawrence Myrick, a renowned neurologist on a quest to cure spinal injuries. With all the ominous lighting and brief but harsh speeches he gives, the movie sets up Dr. Myrick as the villain well before the story actually reveals him to be one, but no matter; Dr. Luthan’s attempts to figure out the mystery and evade capture are enough to carry the movie.

The story begins with a duo of cases in the ER that illustrate the kind of doctor Guy Luthan is. He is brilliant, calm and charismatic, keeping a cool head when two shooting victims arrive in his understaffed and under equipped emergency room. But he also seems ready to make a certain kind of moral compromise. The gunshot wound victims, it turns out, had shot each other. One is a policeman, the other a crack dealer, and outside the ER stand about a dozen policeman watching the proceedings. When Dr. Luthan has to make a snap decision about who to send to the ICU, with the eyes of the police on him and offers of favors, he chooses the policeman despite the fact that the crack dealer’s condition is more serious. Dr. Luthan approaches medicine with a broader frame. Yet he cannot abandon his commitment to individual patients, either, so when a naked and confused homeless man arrives in his ER with bizarre vital signs and nonsensical speech, he dedicates all his intellectual energies to an unsuccessful effort to save him. Even after the patient’s death, Dr. Luthan can’t abandon

(“Review” continues on p11)
the puzzling case, and goes to the morgue to investigate further. The body has vanished, the coroner is surly, and the hospital administrators are convinced that his increasing suspicions are stem from sleep deprivation rather than reality. The deeper he digs, the more his anonymous antagonists push back, framing him for crimes, attempting to destroy him professionally, and preventing him from finding other homeless people who may know about what happened.

The mystery patient, we ultimately learn, was the subject of a medical experiment conducted by the eminent neurologist Dr. Myrick to regrow neurons. Healthy but paralyzed men - often paralyzed by the neurologist himself - were subjected to injections of a modified growth factor that stimulated the growth (but not pruning) of new neurons. Given what we know about Dr. Luthan, how much faith do you have in his ability to do right by the patient, rather than society? How much faith do you put in your own ability to make that decision?

I am unsure whether the artists’ duty when dramatizing ethical issues is to give both sides a fair shake or to build up the side they believe is right. “Extreme Measures,” ultimately, takes the former approach. For all the tension that comes from seeing Dr. Luthan get to the bottom of what happened to his mystery patient, the attitude of the film overall is somewhat more ambiguous. Throughout, there are actors in wheelchairs with partial or total paralysis, a reminder of how many people could benefit from Dr. Myrick’s treatment if it succeeds. The ending, likewise, straddles the line between saying one side is definitely right or wrong, though not necessarily in the way you’d expect. It is a decent way to spend 2 hours if you like your philosophy served with thrills.—

(…“Review” continued from p10)

The past year of public health lectures has taught me a plethora of information that directly applies to my future interactions with patients. Additionally, the public health lectures taught me more about the aspects of public health in particular, more about how public health pertained to the patients and the physicians themselves. I learned more about the social determinants of health as well as different types of health insurance and whether or not that would impact the care that a patient received. All together, I believe that the knowledge I have amassed so far as a result of these lectures will mold my interactions with patients in the future as well as my development as a physician.

One of my first interactions with a diabetic patient at my clinic site involved a conversation about health insurance. During the conversation, the patient mentioned to me how she had reached “the doughnut hole” and she was paying extra for a specific medication even though she had health insurance. She explained the concept of the doughnut hole to me as the point in which certain medications are no longer covered by health insurance and the beneficiary is required to take on the costs themselves.

(“America” continues on p13)
“Moving Forward”
Sumedha Sinha, MS3
2012, Acrylic on Canvas

Inspired by the background of Monet’s The Luncheon. I used it as a way to learn impressionist techniques. Best to copy a master, right?

“Cold as Ice”
Stephanie Dreikorn, MS2
2016, Mix Media

I drew inspiration from the Lana Del Rey song “freak” and it’s based on my own life experiences. It’s supposed to be about a feeling rather than something more concrete.

Share your creativity! To submit artwork for future Scope issues, please contact Khoa at knqdy065@medsch.ucr.edu. Open to students and staff.
Additionally, the only reason that she had gotten to that point is that she kept finding diabetic medications that were more efficient at helping her control her sugar levels in addition to helping her lose weight. Unfortunately, this patient’s dilemma was not unlike that of other thousands of Americans. I perceived the “donut hole” as something more than just a gap in financial coverage. To me, it came across as a gap in someone’s long term health condition. The part that disturbed me is the concept that most medication that is better for a specific condition is more expensive. However, if that is true, then patients that are discovering more expensive medications that would help their conditions will eventually run into a wall in which they can no longer afford any medications at all. In that case, in order to avoid the repercussions of encountering the “donut hole”, patients may be limited to a lower quality of medication than is available and a lower level of healthcare as a result.

The conversation that I had with that patient at my clinic site cleared up a common misconception that I had: the idea or belief that everyone that had health insurance or at least a primary care physician had somewhat equal health benefits. Moreover, as I learned more about healthcare, I was further disillusioned as even equal access to healthcare did not result in equal levels of health among patients. I came to the realization that there were factors other than health insurance that contributed to someone’s health and well-being.

People of a lower status are more likely to have certain working conditions that involve menial labor that would place them at a higher risk of developing musculoskeletal injuries. That meant that two of the patients at my clinic could both have health insurance, but one could already be at the risk of other health issues simply due to his occupation and whatever factors that lead him to that occupation. After I learned about this concept, I began to interact with patients differently. I started considering what factors in their lives could have contributed to the health condition that I was seeing them for as well as the affect that I could have on their health considering those additional factors.

Although there were other determinants of health, I realized that when comparing patients that had healthcare to those that didn’t there was an obvious difference among patients with access to healthcare. Essentially even though Medicare had its flaws and some patients benefitted more from other forms of health insurance, simply having access to healthcare was better than not having healthcare at all.—