Codes in the hospital happen. They happen all the time. They are action packed events of high intensity as physicians and nurses are doing multiple actions to try to keep a person alive. The aftermath is always interesting. Gloves, wrappers, gauze, and tape are strewn all over the floor. The incessant beeping of the monitor just stops—either because the person has been moved or they have passed. Everyone involved leaves and gets back to work, almost like nothing happened. It’s part of the job, keeping a person alive. Any person. They don’t have any connection to the patient generally other than they are on the code team that day.

But the code in clinic left an aura of despair. Many of the MA’s knew the patient well as a friend. They were crushed, crying, and caring. A few had to leave and a few went to the hospital to see the patient. Many of the staff and residents had seen the patient at least a few times and were astonished this had happened. They were worried about the outcome of the patient. A few had also cared for the patient’s family and were concerned for their well-being also. Unlike in the hospital, where a code is run on a patient, this code was run on our patient. The patient was a member of the community for which we care. Perhaps never had I so greatly appreciated what it meant for this clinic and for the providers to be part of the community until a code in the clinic.

- Broadway, 2015

In both the clinic and at the hospital, we work with a number of patients with not only complex chronic health issues but complex social issues including addiction, inter-partner violence and homelessness. Working within this community, we not only have to master medical knowledge but how to navigate complex social issues.

- Broadway, 2015

Just the other day I said goodbye to a couple and their daughter who I had seen five times since her very first newborn visit. I was touched when they expressed how much they would missed my presence, even more so as I reflected on our shared learning experience with their daughter – we all grew in confidence from their first-
time parent questions and my tentative answers to the last visit when we were all more established in our roles. Such continuity and relationship building is an essential and rewarding part of medicine that is left behind in traditional block rotations. In MetroPAP one has the opportunity to truly accompany patients, allowing the therapeutic relationship to mark the difference between a “competent” or “smart” doctor and a good doctor.

Of course, the defining feature of MetroPAP is the chance to experience true longitudinal community-based primary care while focusing on an inspiring but underserved population. From clinic to the hospital to didactics, MetroPAP students develop an understanding of social determinants of health from poverty to racism – and develop the tools to address these head on. This awareness begins with an understanding of and an appreciation for the community served. I loved the opportunity to tackle these issues both interpersonally and intellectually, the former through patient care and the latter through [educational activities]. This is where my journey into medicine finally clicked, where I understood my place as a future clinician and the broader picture of health justice into which I fit.

My passion for social justice has found an outlet in medicine and these nine months have rekindled my energy. I have been taught primary care in its fullest sense – patient-centered and community-based – and have developed the clinical confidence and vigor to tackle the next steps of my education without the slightest hesitation. I am indebted to my patients who confided in me during their most vulnerable moments and my preceptors who trusted and encouraged me in my own.

- Central Ave, 2016