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Writing in medicine

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Writing in Medicine
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Abstract:

Writing is a necessity in the field of medicine. The medical school curriculum has minimal emphasis on writing, with occasional encouragement for reflective journaling. Whether it is communicating between peers, creating a formal well thought-out argument, or just scribbling down conscious thought, writing has always been a therapeutic activity for me. With this project I aimed to hone my writing skills and use writing as a way to promote my ideas and spread information, as well as explore it as a therapeutic tool to help alleviate the stresses of a medical career. In doing this project, I've created an outlet for myself, published a paper, and networked with other like-minded writers.

Methods:

My process began with my ISP proposal—determining how I wanted to incorporate writing in my life. In the early months of my ISP proposal I focused on three things: working on an academic paper, writing reflections on my patients, and writing about musings I have had in medical school.

Writing the academic paper proved the most challenging. I had already performed most of the data collection, and worked tirelessly to analyze several interviews collected in my previous research. The act of writing itself proved to be more difficult because it required a mixture of creativity, along with intellectual analysis. The process of writing including sharing the writing among the group of researchers I was working with in addition to going through several drafts with corrections and suggestions. After our first submission, our paper was rejected with several pages of critiques. Criticized for our methods and the determinations we made from our data, we worked to address the many faults in our paper. With a second round of drafts and edits, we submitted our paper to the Journal of Counseling Psychology. Again we were confronted with edits and critiques, but this time with a chance to resubmit our paper. The process this time was more concrete— we needed to fix the things the editors and reviewers let us know were an issue. We did exactly that and our paper was published in January 2017 (Appendix A).

Another goal of mine was to create a process of journaling/reflections. During my clinical months I would go home after difficult cases and write a brief reflection on a patient I had. In November 2017, I reflected on my 3rd year of medical school and wrote about several of my most memorable patients. This led me to a journey to elaborate on a few of the patients I connected most with and I elaborated on what it was like for me to treat these patients (Appendix B). During my 3rd year I encountered a patient that reminded me of a tragedy I faced at the start of my 3rd

year. I felt it important for me to address many of the issues I had while treating that patient (Appendix C). In another patient reflection I discussed the frustrations encountered with vaccine refusal, something I'm certain to battle in my future career as a pediatrician (Appendix D).

Another goal was to find ways to improve my writing. This included finding opportunities to meet with experts in the field of writing, and attend talks or workshops. I joined a workshop on campus with internal medicine faculty that walked me through how to write a case report. I also attended the American Medical Writers' Association Annual Meeting in Denver, CO. This gave me the opportunity to talk to medical writers from all over the country. These writers came from every aspect of writing including test question writers, freelance writers, manual writers, and bloggers. The most fulfilling experience was watching the keynote speaker, KevinMD, discuss his experience in writing via his blog. In wanting to go to this conference, I wrote short proposal to a scholarship to help fund my attendance.

There were many moments in the last year where I thought, "It'd be interesting to put my thoughts in writing." I often called these medical student musings. I often brainstormed what I would want to write about. In many instances my brainstorms were only that. Other times, I was able to produce something. In one instance I wrote a blog post via the Gold Humanism Honors Society (Appendix E), which reflected my feelings on how my school and a friend's school dealt with student suicide. This process sent me on an adventure to discover what barriers medical schools have to improving medical student well being. I also encountered people responding to my writing, both critically and in support. This is something I have not had much experience with in the past.

With the advent of the 2016 election, I wrote about some other personal feelings I had that were relevant to today's political climate (Appendix F). I also reflected on feelings about the government's distaste for statistics and how it relates to anecdotal medicine (Appendix G). I reviewed several California propositions during the election and documented my thoughts for why I was voting the way I was voting. I did encounter the issue of not enough time, so admittedly I wasn't able to include my thoughts on every single thing that I voted on. I also shared my thoughts with several colleagues, sparking conversations I wouldn't otherwise have. Several of the California propositions were also medically related so I was able to provide a medical student's perspective on how to think about implications of such laws from a health care perspective (Appendix H).

Writing also leaked out into other parts of my life. During my fourth year, I interviewed at 14 different pediatric programs. Knowing that I inevitably would have to compare each of these programs and rank them to participate in the National Residency Matching Program, I realized I would need to reflect on all of my interview experiences. In doing so I created an interview primer that would help myself reflect on the experience and that could also be used in the future for other students who hope to apply into the same programs (Appendix I).

In another part of my life, I became really disheartened to hear that a program I loved in undergrad had been disbanded. I processed those emotions in two ways: by writing a reflection on my experience (Appendix J), and writing a letter to my Alma Mater's provost reflecting on the impact it had in my life (Appendix K). The letter I wrote was deemed impactful enough to be included in a 64 page document produced by one of the band's lawyers to help overturn the school's ruling. The appeal worked.

Reflection has proved to be useful in processing my emotions. In one instance, I felt several anxieties of meeting my partner's family for the first time in Kentucky (Appendix L). In the aftermath of the Match process, I was going through many mixed feelings. I sat myself down and put into writing those feelings (Appendix M), which helped me to cope with my feelings.

Discussion:

Writing has been such an interesting part of my fourth year. Through the stress of trying to impress my attendings, being a sub-intern in a very busy hospital, and applying to residency programs across the country, writing has been a constant for me. There are countless times something significant happened and my first thought was, "I should write about that." There were many instances that as my mind raced with the thoughts of a medical student in a tumultuous time of his life. In many instances, just the act of writing some notes down really helped me to resolve some of the stresses of my life.

This project was also productive. I'm now a published author, a goal that I've had since starting medical school. It gave me an idea of how difficult it is to actually produce writing. It' was very easy for me to have a project on the backburner, and this is one that I needed to set deadlines for myself to accomplish. It was with the help of a team of people that we were able to get it submitted and published. In doing so, I recognized several avenues that I could access help in improving my writing. I attended workshops, and sought help from peers. I learned that it's easy to feel vulnerable when sharing any piece of writing.

In reflecting on my writing, there are some things I've come to acknowledge. While I have written a lot in quantity, I still need to work on quality. There are many instances that I hoped to produce something I was very proud of and would wanted to share, but often fell short of something that truly fit that criterea. But I did realize that with a file full of failures, comes one or two things that I did want to share. And although my audience was often times, small and among friends, the feedback I received was almost always useful to me.

Improving my writing is important to me. And it's a journey that takes a lot of time and energy. I don't consider myself a great writer, but I at least find myself more

inclined to do it. There are so many reasons to write, and this year I've only uncovered a few of those reasons. In attending the American Medical Writers' Association annual meeting in Denver this past year, I met so many different people who use writing as a vital part of their careers. It's important to be able to disseminate information intelligently and that's exactly what so many of the people I met were doing.

With all of this said, there were still many shortcomings in my proposed project. I thought big and fell short in many areas. I hoped to show the power of writing to my younger peers. And in some avenues I hit dead ends. In others I had a productive conversation with my peers and school administrators. I found that with such broad goals and with lots that I wanted to do, there were often things left out. With time being the significant factor in these shortcomings, I realized very quickly that time and my opportunities to affect change were finite. As I wrap up my fourth year, I know there is still more to do and hope that wherever I go I can bring not only these skills I have gained with me, but can also bring the aspirations and goals I wasn't able to accomplish here.

The things I'll take with me to my future are plentiful. The concept of brainstorming and planning are very important and will help me in any future writing that I hope to do. I now have access to more mentors willing to review and critique my writing. I have a keen understanding of what it is like to journal and can appreciate taking that time out of my day as an investment in my emotional well-being. With this learned appreciation, my goal is to continue writing, and to improve my ability to convey my thoughts. I do feel that my writing and confidence has grown in the past year and will continue to grow with continued practice.

Appendix A:

Imagining the Future: Perspectives Among Youth and Caregivers in the Trans Youth Family Study

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Future perspectives of transgender youth and their caregivers may be shaped by knowledge of discrimination and adverse mental health among transgender adults. Qualitative data from the Trans Youth Family Study were analyzed to examine how transgender and gender nonconforming (TGN) youth and their caregivers imagine the youth's future. A community-based sample of 16 families (16 TGN youth, ages 7–18 years, and 29 caregivers) was recruited from 2 regions in the United States. Participants completed in-person qualitative interviews and surveys. Interview transcripts were analyzed using grounded theory methodology for coding procedures. Analyses yielded 104 higher order themes across 45 interviews, with 8 prominent themes: comparing experiences with others, gender affirming hormones, gender affirming surgery, gender norms, questioning whether the youth is really transgender, expectations for romantic relationships, uncertainty about the future, and worries about physical and emotional safety. A conceptual model of future perspectives in TGN youth and caregivers is presented and clinical implications are discussed.

Public Significance Statement
This research suggests that transgender and gender nonconforming (TGN) youths' and their caregivers' perceptions of the youth's future are related to societal norms about gender and knowledge of discrimination against transgender individuals. Clinical work and interventions for families with TGN youth should consider how TGN youth and caregivers are thinking about the youth's future and how this may impact the family's ability to support the youth in their gender transition.

Keywords: transgender youth, gender identity, family, parent–child relationships, future orientation

As the field of psychology as a whole has moved from pathologizing transgender individuals (Drescher, 2010), toward affirming and understanding their experiences, counseling psychology has played a critical role in guiding clinical service provision and conducting research, which affirms transgender identities. Transgender and gender nonconforming (TGN) individuals have a dif-

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ferent gender identity and/or expression than their sex assigned at birth. *Transgender* is generally conceptualized as an umbrella term that encompasses a number of diverse gender identities including genderqueer, trans woman, trans man, agender, and transsexual, among a host of other terms (Davidson, 2007). Conversely, the term *cisgender* is used to describe individuals for whom their gender identity is aligned with their sex assigned at birth.

The literature on transgender individuals has grown extensively and rapidly in recent years, with the experiences of transgender youth and their families in particular, obtaining more specific attention. A great deal has been learned about psychological and medical service provision to transgender youth and their families (e.g., Coolhart, Baker, Farmer, Malaney, & Shipman, 2013; Edwards-Leeper & Spack, 2012; Vance, Halpern-Felsher, & Rosenthal, 2015), barriers to appropriate care for transgender youth (Gridley et al., 2016; Vance et al., 2015), discrimination and stigma faced by transgender youth (e.g., Ignatavicius, 2013; McGuire, Anderson, Toomey, & Russell, 2010; Veale et al., 2015), the important role family support plays in supporting the psychological well-being of transgender youth (Simons, Schrager, Clark, Belzer, & Olson, 2013; Travers et al., 2012; Veale et al., 2015), and the identity processes and resilience of transgender youth (e.g., Difulvio, 2015; Grossman, D'Augelli, & Frank, 2011; Pollock & Eyre, 2012; Singh, Meng, & Hansen, 2014; Testa, Jimenez, & Rankin, 2014).

Although recent scholarship has begun to provide a better understanding of the experiences and needs of transgender youth and their families, there is still much work that needs to be done. In particular, there is a very limited understanding of how transgender youth and their families conceptualize the future of transgender youth. Although some studies of transgender youth have investigated important contributors to future perspectives (i.e., how people think about the future), such as the broader social context and the more proximate family system, no study has explicitly examined the future perspectives of transgender youth and their families. The aim of this exploratory qualitative study was to examine TGN youths' and caregivers' perceptions of the youth's future in light of the youth's gender identity, and in turn, use this data to inform counseling interventions.

Future Perspectives

Future perspectives can be defined as "the images humans develop regarding the future, as consciously represented and self-reported" (Seginer, 2009, p. 3). In taking a thematic approach to understanding future perspectives, reviews of the literature (Massey, Gebhardt, & Garnefski, 2008; Nurmi, 1991; Seginer, 2009) have found that six life domains tend to predominate the future orientation of youth: education, work and career, marriage and family, self-concerns (i.e., general images of the self, mood states, and personality characteristics), others (i.e., general images of other individuals like friends and family), and collective issues (i.e., images of society, one's community, one's nation, and the world). However, the specific content of future perspectives and other life domains that might be salient for youth may vary greatly depending on social and familial contextual factors, such as the beliefs, values, norms, and living conditions youth experience. Future perspectives across life domains tend to reflect major developmental tasks of adolescence and early adulthood and man-

ifest through hopes, goals, and expectations (e.g., wanting to pursue a particular job or career, hoping to be happy or courageous), as well as fears and concerns (e.g., fearing failure at school or future divorce).

In a study focused exclusively on caregivers of transgender youth, caregivers expressed fears for their children's safety, happiness, and adjustment (Hill & Menvielle, 2009). Given that parental beliefs and future perspectives have been shown to influence how cisgender adolescents think about their future (Seginer & Mahajna, 2016; Seginer & Shoyer, 2012), it may be that these fears also influence the future perspectives of transgender youth. Among transgender adults, future perspectives have been investigated in the form of anticipated stigma (Golub & Gamarel, 2013) and potentially traumatic events (Shipherd, Maguen, Skidmore, & Abramovitz, 2011); however, these studies are focused on specific aspects of future perspectives and are limited to specific populations in the transgender community. No studies have explicitly sought to understand how both transgender youth and caregivers conceptualize their futures across various life domains.

Among cisgender adolescents, future perspectives are associated with various life outcomes, including: academic achievement (Scholtens, Rydell, & Yang-Wallentin, 2013); violent behaviors (Stoddard, Zimmerman, & Bauermeister, 2011); identity formation (Sharp & Coatsworth, 2012); and adult alcohol use, civic behaviors, and social roles (Finlay, Wray-Lake, Warren, & Maggs, 2015). Future perspectives have also been shown to explain the association between traumatic events and depression, loneliness, and self-esteem among youth (Zhang et al., 2009). Among young adults, future thinking partially explains the association between suicide motivation and depressive symptoms and the association between suicide motivation and hopelessness (Chin & Holden, 2013). Additionally, parental support and acceptance are associated with cisgender youth having positive expectations and a greater sense of personal control over the future (Lanz & Rosnati, 2002; Pulkkinen, 1990; Seginer, Vermulst, & Shoyer, 2004). Although no studies have explicitly examined the future perspectives of transgender youth, the social and family contexts which influence the development of future orientation (Massey et al., 2008; Nurmi, 1991; Seginer, 2009), have received attention in the literature.

Social Context, Discrimination, and Mental Health

In the United States, when people exhibit behaviors or present themselves in ways that do not conform to the gender norms associated with their sex assigned at birth (i.e., are gender nonconforming) they are likely to experience negative repercussions for the violation of those gender norms (Ohbuchi et al., 2004). The U.S. National Transgender Discrimination Survey, which sampled nearly 6,500 transgender adults, found that 12% of participants who expressed their transgender identity or exhibited gender nonconformity in kindergarten through 12th grade reported being sexually assaulted by another student, a teacher, or a staff member; and 35% reported being physically assaulted and 78% reported experiencing harassment (Grant et al., 2011). The Canadian Trans Youth Health Survey found that two thirds of the 923 youth surveyed reported discrimination based on their gender identity, 70% had experienced sexual harassment, and 36% were physically threatened or injured during the last year (Veale et al., 2015).

In addition to discrimination and victimization, transgender individuals face alarming rates of adverse mental health outcomes, including suicide attempts reported by 41% of transgender adults (Grant et al., 2011), rates of depression ranging from 44–65%, and rates of anxiety ranging from 33–45% (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Budge, Adelson, & Howard, 2013; Tebbe & Moradi, 2016). These rates are substantially higher than the general U.S. adult population, in which 4.6% of adults report attempting suicide (Nock, Hwang, Sampson, & Kessler, 2010), 6.7% of adults report having at least one major depressive episode over a 12-month period, and 11.1% report a diagnosable anxiety disorder over a 12-month period (Substance Abuse and Mental Health Services Administration, 2014). In a study of youth who receive care from an urban clinic, transgender youth were found to be at two to three times higher risk than matched cisgender controls for nonsuicidal self-injury, suicidal ideation, suicide attempt, depression, and anxiety (Reisner et al., 2015). Minority stress theory postulates that stigma, victimization, and other forms of discrimination experienced by TGN people are the primary contributors to adverse mental health outcomes in this population (Hendricks & Testa, 2012; Meyer, 2003). Therefore, the high rates of suicide attempts, depression, and anxiety among transgender people result from the adversity transgender people face.

The disparities seen across mental health outcomes may themselves reveal aspects of future perspectives expressed by some transgender youth. Suicide and suicidal behaviors have demonstrated a consistent relationship to hopelessness (Klonsky, May, & Saffer, 2016), which itself represents negative expectancies about the future (Beck, Weissman, Lester, & Trexler, 1974). Negative views about the future are also one component of the cognitive triad formulated by Beck to conceptualize depression (Beck, 1976), and anxiety itself is characterized by worry or "apprehensive expectation" over the future (American Psychiatric Association, 2013). The social context of discrimination and victimization experienced by transgender youth and the resultant minority stress they experience could therefore lead to fears, concerns, and negative views of the future, which may then lead to the mental health disparities that have been observed.

Although these disparities indicate a need for mental health services, an important aspect of the social context for transgender youths' lives is the presence of significant barriers to accessing gender-affirmative mental and physical health care in the United States. Transgender youth and their caregivers have identified a number of these barriers, including a lack of accessible health care providers who work with children and have training in gender affirming care, a lack of consistency in protocol use, use of incorrect names or pronouns, gatekeeping and lack of coordinated care, delayed or limited access to pubertal blocking medications and hormones, and exclusion from insurance policies (Gridley et al., 2016). Health care providers themselves have identified a lack of training, limited to no exposure to transgender patients, lack of qualified mental health clinicians, and difficulty obtaining insurance reimbursement for transgender-related care (Vance et al., 2015). Without appropriate access to care, transgender youth may have difficulty realizing the future they see for themselves and these barriers likely influence the hopes, goals, expectations, fears, and concerns they have related to their futures.

Family Support

Although transgender individuals are disproportionately subject to adversity, transgender youth who receive higher levels of support from their families have been shown to experience better mental health outcomes, including lower likelihood of engaging in nonsuicidal self-injury, lower rates of suicidal ideation, fewer suicide attempts, fewer depressive symptoms, a decreased sense of burdensomeness stemming from the youth's transgender identity, higher self-esteem, and higher levels of life satisfaction (Simons et al., 2013; Travers et al., 2012; Veale et al., 2015). Although family support may play a critical role in sustaining the mental health and well-being of transgender youth, few studies have examined the experiences of caregivers of transgender youth. Caregivers may have a range of reactions when they first learn about their transgender youth's gender identity including surprise, feeling a sense of loss, supporting the youth with love, viewing their youth's gender-nonconformity as a phase, seeing the youth's gender identity as a symptom of a resolvable psychological issue, psychologically abusing the youth, or physically abusing the youth (Grossman, D'Augelli, Howard, & Hubbard, 2005; Tishelman et al., 2015). Some of these reactions may be associated with how caregivers see the future of their transgender child and the way transgender youth see their own future.

Current Study

Given the influence of social and familial contextual factors on future orientation, the unique social context of transgender youth, the importance of family support to the well-being of transgender youth, and the relationship between future perspectives and various outcomes related to mental health that have been found among cisgender youth, the aim of the current exploratory study was to examine how TGN youth and their caregivers perceive the youth's future in light of the youth's transgender identity. Specifically, the study sought to answer the following research questions:

> *Research Question 1:* What are the primary themes and life domains around which TGN youth and their families focus their future perspectives?

> *Research Question 2:* How does the unique social context of TGN youth influence the way TGN youth and their caregivers think about the youth's future?

> *Research Question 3:* How might the themes and life domains of future perspectives identified by TGN youth and their caregivers relate to one another?

Qualitative data were analyzed from TGN youth and caregiver interviews from the Trans Youth Family Study, a multisite mixed methods study of families with TGN youth.

Method

Participants

Participants were 16 families, including 16 TGN youth, ages 7–18 years ($M = 12.55$, $SD = 3.86$), and 29 cisgender (nontransgender) caregivers (Total individual $N = 45$). Youth self-identified their current gender identity as trans boy ($n = 9$), trans

girl ($n = 5$), gender-fluid boy ($n = 1$), and girlish boy ($n = 1$). Caregivers included mothers ($n = 17$), fathers ($n = 11$), and one grandparent. Other sample demographics are reported in Table 1. Participants were recruited from lesbian, gay, bisexual, transgender, and queer (LGBTQ) community organizations and support networks for families with transgender youth in New England and the lower Midwestern United States, as well as via snowball sampling. Youth were eligible to participate in the study if they were age 5–18 years and identified with a different gender from

their assigned birth sex (e.g., transgender, trans) or were gender nonconforming. Caregivers were eligible to participate if they had a youth who met the above criteria. Youth and at least one caregiver were required to participate in the study together. Volunteers were asked to participate in a study about the experiences of transgender youth and their caregivers, including emotional experiences and perceptions of the youth's gender identity.

Researchers

The authors of this study represented a diversity of perspectives stemming from varying life experiences related to holding different social positions and identities. Katz-Wise is a White queer (non-heterosexual) cisgender female research scientist and instructor who is trained in developmental psychology, gender and women's studies, and social epidemiology and has expertise in research with transgender youth and families. Budge is a White queer (non-heterosexual) female professor of counseling psychology with expertise in research with transgender populations. Katz-Wise and Budge are co-principal investigators of this study. Orovecz is a White gay male doctoral student in counseling psychology and focuses his work on LGBTQ issues and crisis and suicide prevention and intervention. Nguyen is a Vietnamese American gay male medical student. Nava-Coulter is a biracial queer graduate student in sociology, whose work focuses on gender and sexuality. Finally, Thomson is a White queer (non-heterosexual) cisgender female clinical child and adolescent psychologist. The first five authors were interviewers and Thomson was part of the on-call mental health team for the study. Katz-Wise, Nguyen, and Nava-Coulter completed the data analysis and Katz-Wise, Budge, Nguyen, and Nava-Coulter participated in formulating a conceptual model from the themes identified during analysis. Other members of the research team who assisted in conducting and transcribing interviews were graduate students in counseling psychology, clinical psychology, public health, and human development.

When we began this analysis, we were unable to locate any previous literature that had examined future perspectives in families with transgender youth. Therefore, our assumptions were largely based on team members' previous experiences with transgender research and the general impressions of the team members based on conducting interviews for the study. We began with the assumption that exposure to adverse outcomes (e.g., discrimination, mental health issues) experienced by transgender individuals in the media and outside of the participants' families would shape participants' thoughts about the youth's future as it relates to their gender identity. We expected caregivers to be more future-oriented than youth and to have a more negative outlook of the youth's future than the youth themselves. Finally, we expected that participants' future perspectives might differ based on the age of the youth, how much time had passed since the youth came out as transgender, and how their coming out was received by family and friends.

Table 1

Sample Demographics for Transgender Youth and Caregivers From the Trans Youth Family Study

Measure	Youth ($N = 16$)	Caregivers ($N = 29$)	Families ($N = 16$)
Age in years, M (SD)	12.55 (3.86)	47.45 (7.06)	
Sex assigned at birth, % (n)			
Female	56.3 (9)	62.1 (18)	
Male	43.8 (7)	37.9 (11)	
Current gender identity, % (n)			
Cisgender woman		62.1 (18)	
Cisgender man		37.9 (11)	
Trans girl/girl	31.3 (5)		
Trans boy/boy	56.3 (9)		
Other	12.5 (2)		
Race/ethnicity, % (n)			
White	87.5 (14)	75.9 (22)	
Hispanic/Latino		3.4 (1)	
Multiracial/other	12.5 (2)	20.7 (6)	
Education, % (n)			
High school diploma/GED		3.4 (1)	
Some college		6.9 (2)	
College degree		48.3 (14)	
Graduate degree		41.4 (12)	
Individual income, % (n)			
$10,000–30,000		10.3 (3)	
$30,001–60,000		24.1 (7)	
$60,001–100,000		24.1 (7)	
≥$100,001		37.9 (11)	
Retired		3.4 (1)	
County of origin, % (n)			
United States		89.7 (26)	
Non-United States		10.3 (3)	
Current geographic location, % (n)			
New England			81.3 (13)
Midwest			18.8 (3)
Sexual orientation, % (n)			
Heterosexual/straight	31.3 (5)	82.8 (24)	
Bisexual	12.5 (2)	6.9 (2)	
Lesbian/gay	6.3 (1)	6.9 (2)	
Pansexual	6.3 (91)		
Unsure	43.8 (7)		
Other		3.4 (1)	
Relationship status, % (n)			
Single		3.4 (1)	
Married		79.3 (23)	
Living with partner (unmarried)		6.9 (2)	
Separated/divorced		10.3 (3)	
Widowed		3.4 (1)	

Note. Caregiver age range = 34–63 years; youth age range = 7–18 years. All cisgender men were fathers; 17 out of 18 cisgender women were mothers; 1 was a grandmother. Other gender identities included gender-variant and "girlish boy." Frequencies for languages used at home, religion practiced at home, and relationship status were overlapping because participants could choose or write in more than one option.

Measures

The interview protocols for TGN youth and caregivers were semi-structured and developed for the current study. Separate developmentally appropriate interview protocols were developed for TGN youth age 5–11 years, TGN youth age 12–18 years, and

caregivers. Interview questions addressed perceptions of the youth's gender identity development, emotions and coping related to the youth's gender identity, effects of the youth's gender identity on relationships within and outside of the family, and support needs. The primary interview questions of interest for the current study assessed effects of the youth's gender identity on the youth's future; however, each transcript was analyzed as a whole for themes related to future perspectives. Caregivers were asked, "Describe the future that you imagine for your child, considering their gender identity" with the following probes: "How do you think your child's gender identity might affect their future?" and "How has your thinking about this changed compared to when you first learned about your child's gender identity?" Youth age 5–11 years were asked, "When you grow up, how do you think your life might be different from your friends?" and youth age 12–18 years were asked, "How do you think your transgender identity will affect your future?" If youth age 5–11 years did not mention their gender identity, they were probed regarding whether they thought their life might be different based on their gender identity.

Procedure

Study sessions were conducted between April and October 2013 in participants' homes or at the researchers' institutions. All participants gave informed assent/consent prior to participating. Study sessions lasted approximately two hours and consisted of one-on-one in-person semi-structured qualitative interviews with each family member in separate rooms, followed by completion of a short quantitative survey. All interviews were digitally recorded and transcribed verbatim by graduate students from the researchers' institutions. Participants were not offered compensation for participating in this study due to funding constraints. This study was approved by the Institutional Review Board at each study site.

Analytic Methodology

Interview transcripts were analyzed by Katz-Wise, Nguyen, and Nava-Coulter using grounded theory methodology for the coding procedures (Charmaz, 2014). Data from youth and caregivers were combined because the interview protocols for the two types of participants contained parallel questions that yielded similar content and themes. Prior to beginning the coding procedures, the coders met to discuss and document their biases and assumptions. These notes were revisited throughout the analytic phases, as well as during the writing of this report. First, two coders completed initial (line by line) coding separately for each transcript and came to consensus, during which any discrepancies in the coding were discussed and resolved. During this phase, lines from the transcript were coded into more concise statements. Second, two coders completed focused coding, in which line by line codes were categorized into higher order codes by consensus. Line by line codes could be categorized into more than one higher order code. The first two phases were completed for each transcript prior to moving on to the next transcript to allow for constant comparison. Higher order codes were created across all participants without regard to participant type (e.g., youth vs. caregivers, mothers vs. fathers). Third, all members of the research team completed the theoretical coding phase. In this phase, higher order codes were placed into broader themes and a conceptual model was generated to describe the phenomenon of perspectives of TGN youths' futures. Prior to theoretical coding, Budge audited the results of the first two coding phases by reviewing the categorization of line by line codes into higher order codes.

Results

Conceptualizations of Future Perspectives

Future perspectives have been defined rather broadly as images of the future that are "consciously represented and self-reported" (Seginer, 2009, p. 3), without reference to the timeframe of future. In the current study, we identified three different conceptualizations of future perspectives: (a) past conceptualizations of the future, (b) conceptualizations of the short-term future, and (c) conceptualizations of the long-term future. Past conceptualizations of the future were present in participants' narratives when they reflected on how they thought about the future at an earlier time. For instance, caregivers of older TGN youth talked about when their child first came out as transgender and how they anticipated their child's future at that point. This was often contrasted with feeling differently about the youth's future now that the youth was older. Conceptualizations of the short-term future were present in participants' narratives when they expressed concerns related to the youth's immediate future, such as worries related to summer camp or school in the weeks or months following the interview. Finally, conceptualizations of the long-term future were present in participants' narratives when they expressed concerns related to the youth's individual long-term future and/or the long-term future of the larger society, such as discussions of college for younger youth, or marriage for youth of any age. The long-term future of the larger society was described in thinking about acceptance of TGN individuals and transgender rights. The classification of short-term versus long-term future was interpreted on an individual participant basis, as short-term and long-term may be different for TGN youth of different ages or at different stages of transgender identity development.

Conceptual Model of Future Perspectives

We identified 104 higher order themes overall across the 45 interviews. The full list of higher order codes, the number of line by line codes within each code by type of participant (youth vs. caregiver), and the broader theme in which each code was placed is shown in Table 2. Below we describe higher order codes in the model that were considered prominent, as represented by 20 or more line by line codes. When there was more than one prominent code, we describe a subset of the codes. The higher order codes were categorized into broader themes, which were organized into a conceptual model of future perspectives (see Figure 1). In the model, themes represent a primarily linear process, with interplay among different contextual factors. Societal factors appear on the left-hand and right-hand side of the model to represent the beginning and end of the process. These types of factors were experiences that represented societal-level institutions (e.g., religion), social constructs (e.g., gender norms), and societal attitudes toward TGN individuals. Moving from left to right in the model, societal factors created barriers to envisioning a positive future for

Table 2

Higher Order Themes and Number of Line by Line Codes

Category	Higher order theme	Total line by line codes	Line by line codes from caregiver interviews	Line by line codes from youth interviews
Societal factors	Comparing experiences	60	53	7
	Gender norms	43	42	1
	Passing	19	11	8
	Societal views of LGBTQ issues	11	8	3
	Fitting in	9	8	1
	Social interactions	6	5	1
	Living as identified gender will be easier	5	4	1
	Religion	5	4	1
Barriers to envisioning a positive future	Discrimination	27	24	3
	Policies and rights	23	21	2
	Insurance and finances	21	17	4
	Romantic relationships—concerns	18	15	3
	Rejection	17	14	3
	Discrimination—bullying	14	14	0
	Discrimination—employment	11	7	4
	Legal issues (e.g., official documents)	10	7	3
	Perceived as unusual	7	7	0
	Barriers to gender affirming treatment	5	4	1
	Attractiveness	4	4	0
	Difficulty imagining youth's future	4	4	0
Advocacy	Activism	25	23	2
	Knowledge/education about transgender	14	14	0
	Helping others	12	11	1
Acceptance/Support	Supportive communities—youth	31	28	3
	Supportive communities—caregivers/family	27	27	0
	Being a good caregiver	26	26	0
	Wanting the best for youth	25	25	0
	Acceptance—interpersonal	24	21	3
	Acceptance—broad	21	16	5
	Being a good caregiver—support	18	18	0
	Being a good caregiver—skills and preparation	15	15	0
	Being a good caregiver—protection	10	10	0
	Seeking support/resources	9	8	1
Mental health/emotions	Worry about safety—physical and emotional	48	46	2
	Emotions—fear	34	34	0
	General worry about future	31	30	1
	Mental health—happiness	22	21	1
	Emotions—positive	16	15	1
	Mental health	15	14	1
	Emotions—sadness/grief	14	14	0
	Emotions—anxiety	13	13	0
	Reassurance	12	12	0
	Comfort with body	11	11	0
	Emotions—hardship	10	10	0
	Mental health—suicidality	7	7	0
Relationships	Friendships	24	18	6
	Caregiver–child relationship	22	19	3
	Caregiver discordance or agreement	17	17	0
	Relationships with extended family	14	14	0
	Parent–parent relationship	5	5	0
	Effect of having transgender sibling	3	3	0
Approaching the adjustment	Uncertainty about the future	39	34	5
	Is my child really transgender?	36	34	2
	Planning/preparation	34	30	4
	Decision-making about being out	28	12	16
	Desire for certainty	14	14	0
	Perseverance/determination	6	4	2
	Avoidance of thinking about youth's future	5	5	0
	Going with the flow/being flexible	5	5	0

Table 2 (*continued*)

Category	Higher order theme	Total line by line codes	Line by line codes from caregiver interviews	Line by line codes from youth interviews
	Origin of being transgender	5	5	0
Expectations	Romantic relationships—expectations	35	23	12
	Expectations about coming out	31	20	11
	Self-sufficiency	30	30	0
	Ideal expectations for youth's future	29	24	5
	Societal views of LGBTQ issues—hopes for future	27	25	2
	General expectations about youth's/family's future	23	20	3
	Youth's future family	23	21	2
	Difficult future/challenges	19	18	1
	Normative expectations	15	15	0
	Sexual orientation—caregiver expectations	15	15	0
	Change in expectations	13	12	1
	Reproduction	10	9	1
	Positive effects of being transgender	6	3	3
	Transgender identity won't affect future	6	1	5
	Sexual activity	5	4	1
Identity	Authenticity	28	27	1
	Personality and behavior	23	23	0
	Desire to be another gender	19	18	1
	Names	17	14	3
	Transition process	17	13	4
	Sexual orientation—youth self-identification	10	6	4
	Emphasis on youth's transgender identity	8	3	5
	Genitals	8	8	0
	Self-fulfillment	8	8	0
	Fluidity of transgender identity	6	3	3
	Gender spectrum/genderqueer	4	4	0
	Maintaining attributes	4	4	0
Institutional factors	Camp	34	27	7
	School—precollege	32	26	6
	Employment/career—youth, specific careers	30	14	16
	Employment/career—youth, work issues	28	16	12
	College	14		11
	Changing schools/moving cities	13	9	4
	Facilities (e.g., bathroom)	12	9	3
	Employment/career—caregiver	10	10	0
	College—housing	7	7	0
Health/Interventions	Gender affirming treatment—hormones	45	42	3
	Gender affirming treatment—surgery	37	27	10
	Gender affirming treatment—feelings	32	30	2
	Professional help	30	27	3
	Gender affirming treatment	13	12	1
	Puberty	9	9	0
	Health	5	5	0

Note. LGBTQ = lesbian, gay, bisexual, transgender, and queer.

families with TGN youth, such as anticipating experiences of discrimination and rejection. These barriers then influenced a number of other experiences, which were grouped into four categories: (a) advocacy; (b) acceptance/support, mental health/emotions, relationships; (c) approaching the adjustment, expectations; and (d) identity. Categories b and c combined multiple larger themes because they were thematically related. Continuing to move toward the right-hand side of the model, these experiences then informed institutional factors (e.g., school, employment) and health/interventions in the individual youth's short-term future and society's long-term future.

Societal Factors

As described above in the conceptual model, societal factors first influenced barriers to envisioning a positive future and then affected perceptions of the long-term future. The two most prominent higher order codes (represented by 20 or more line by line codes) in societal factors were *comparing experiences with others* and *gender norms*. In imagining the youth's future, participants compared the youth's experiences with other TGN youth and adults, cisgender youth, and lesbian, gay and bisexual (LGB) individuals. One youth participant compared himself with other TGN individuals when describing his short-term
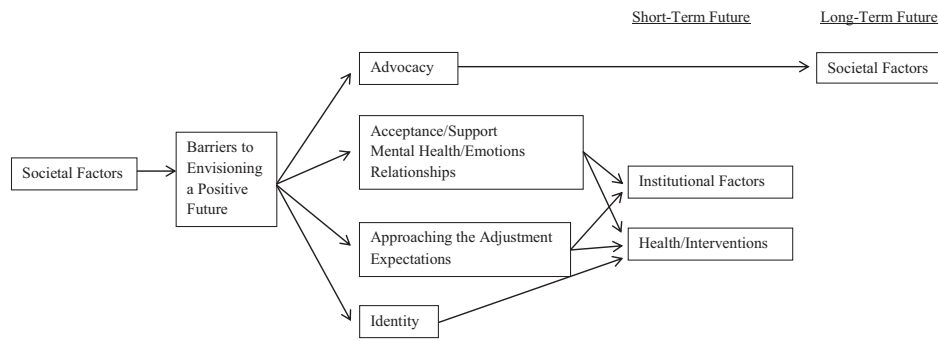
Figure 1. Conceptual model of transgender youths' and caregivers' future perspectives.

future: ". . . a lot of people, [being transgender] sort of affects their future. I haven't really let it affect my future. I still get good grades; I've graduated with honors, I'm going to a good university . . ." (trans boy, age 18 years).

For some caregivers, meeting or talking to TGN adults gave them perspective on their child's long-term future. A mother of a trans boy, age 18 years, described talking to a trans man about his experience,

> I said "Listen, thank you for talking to me. I really want to ask you some invasive questions, because I need to understand what is coming down the road for us. I need to know your journey so that I can understand what ours might be."

At times, talking to a TGN adult was reassuring to caregivers, as in the narrative of a father of a trans boy, age 15 years,

> . . . just to meet a happy, healthy, well-adjusted male and to see that [child] could end up being a happy, healthy, well-adjusted male was like such an amazing relief . . . I think that helped so much. Just that this doesn't have to be a freak show. It doesn't have to be bizarre. This doesn't have to be, you know, somebody with tattoos all over their body . . . this can just be a happy, healthy, well-adjusted male child.

Gender norms was a prominent code within the broader theme of societal factors that included appearance (e.g., body size, clothing, hair length and style), personality and behavior (e.g., being sensitive), interests (e.g., sports), and gender roles (e.g., careers). In one parent's past conceptualization of the future, she described concern about her child's future romantic relationships due to his body size being atypical for a male, "I used to worry in the beginning . . . he's so small, whose gonna love him? I worried about his physical size . . . I worried that that would hold him back from having a future with somebody" (mother of a trans boy, age 18 years). An 8-year-old youth participant who identified as a "girlish boy" similarly worried about other people's reactions related to gender norms in the long-term future, as told by his mother,

> He said [to me], "But I'm not going to get married, because if I married a boy I'd want to be the bride . . . I would want to wear a dress and people would laugh at me because I'm marrying a boy and I'd be wearing a dress."

Barriers to Envisioning a Positive Future

Societal factors produced barriers to envisioning a positive future for families with TGN youth. Barriers included prominent higher order codes such as *general discrimination*, *insurance and finances*, and *policies and rights*. Participants talked about specific types of discrimination, such as bullying and employment-based discrimination, but also discrimination in general. Some participants described actual experiences with discrimination, as seen in a parent's description of an interaction that her child experienced, ". . . his girlfriend's mother freaked out and said, 'You're disgusting' and forbid her from seeing him" (mother of a trans boy, age 18 years), which made the participant realize that discrimination will be a part of her child's future life, both in the short-term and long-term. Other participants anticipated discrimination based on their knowledge about discrimination among other TGN individuals.

The theme of insurance and finances arose primarily in relation to gender affirming treatments for the TGN youth, such as pubertal blockers, hormone therapy, and surgical procedures. A youth participant described the complexities of navigating insurance as a TGN individual, in terms of their long-term future, ". . . all my medical stuff is still listed as female, which I was advised to do because that way if you get cervical cancer or breast cancer or whatever your insurance will cover it" (trans boy, age 17 years). Regarding finances in the long-term future, one parent said, ". . . it's a financial concern, just that I'll be able to afford the therapies that [my child] needs" (mother of a trans boy, age 10 years).

Participants also discussed policies and rights, such as nondiscrimination policies in school settings and TGN rights more generally. Many caregivers described how policies and laws shaped how they thought about their child's future. A father of a trans girl, age 8 years, talked about hoping for change to happen at all the schools in the district regarding nondiscrimination policies, saying, ". . . once that happens . . . then I'll feel more comfortable about middle school and high school." A mother of a trans girl, age 15 years, talked about societal change more broadly in relation to how she imagines her child's long-term future now, compared to when her child came out as transgender 12 years prior,

> I think it's more positive because I see that the United States is changing . . . the laws are passing that are good laws that are going to

protect [child] and give her the same rights that everybody else has in the country.

Advocacy

The barriers to envisioning a positive future anticipated by family members appeared to influence other experiences, such as advocacy. The most prominent code in advocacy was activism. Having a TGN youth in the family prompted some participants to engage in activism related to transgender rights. As a mother of a trans girl, age 13 years, described,

> We've taken . . . the opportunity to do some advocacy . . . to make this world a better place for [child], you know, to raise awareness and to make it more familiar. I think about all the kids in her class that will go, "Oh yeah, I had a kid in my class that was trans," like no big deal, you know.

For some participants, activism was a form of empowerment and created opportunities for the youth's long-term future, as in the narrative of a trans girl, age 15 years,

> I think [being transgender] has definitely given me options for what I can do for a career. I know that I can always fall back on activism and stuff, maybe like something in law regarding this type of situation. So it's given me a firm basis for everything.

Acceptance/Support, Mental Health/Emotions, Relationships

Barriers to envisioning a positive future anticipated by family members also affected experiences related to acceptance/support, mental health/emotions, and relationships. These three themes were grouped together because acceptance/support from others was directly associated with participants' mental health/emotions and relationships and vice versa.

Acceptance/support. Acceptance/support included prominent higher order codes such as *being a good caregiver*, *supportive communities for the youth*, *supportive communities for the caregivers and family*, and *wanting the best for the youth*. The concept of being a good caregiver emerged in a number of different higher order codes found primarily among caregivers, including wanting to protect their child, wanting to give their child skills and prepare them for the future, and providing support. One parent described being a good parent in relation to her child's short-term future, ". . . the safest, smartest thing I could do is get this child on the path to being who he feels like he is so that he can start feeling like he belongs" (mother of a trans boy, age 15 years). A father of a trans girl, age 15 years, described wanting to give his child skills for their long-term future,

> . . . the next thing for me as a parent, as a tactical dad, is to try to get [child] life skills to take care of herself, and I'm having some challenges with that because all the life skills that I have . . . aren't any good for a trans kid . . . how do you teach 'em when you do not know?

Supportive communities for the youth and caregivers primarily referred to the importance of such communities to the participants' long-term future well-being. As one parent said, "I think friends and community are a big part of living a fulfilled life; I think those are still very possible for [child]" (mother of a trans boy, age 17 years). Similarly, many caregivers talked about wanting the best

for their child in both the short-term and long-term future. One parent described this sentiment in relation to her child undergoing a gender transition, "I want a happy, adjusted child who feels good about himself and who feels good about the world and if [gender transition] is what it takes, then that's what it takes. Let's get going!" (mother of a trans boy, age 15 years).

Mental health/emotions. Mental health/emotions included prominent higher order codes such as *fear*, *general worry about the future*, *worries about physical and emotional safety*, and *happiness*. Caregivers expressed fear about a number of different aspects of their child's short-term and long-term future, including gender affirming medical treatments (e.g., surgery) and interacting with other people, as a father of a trans boy, age 15 years, said,

> It's one thing to think of your kid as trans. It's another thing thinking of your kid in the hospital going through surgeries and going through gender reassignment, going through all kinds of hormonal treatments and things like that . . . [it's] very scary. It's very upsetting to me, and it's taking it from an abstraction to a reality.

Caregivers' worries about physical and emotional safety were largely related to anticipated violence against their child because of their child's transgender identity. One parent said she worries about her child's short-term future in that, ". . . [child] will go to a playdate at someone's house and they'll be like a psycho-conservative person who goes and kills children like that 'cause they're doing a favor to the world" (mother of a trans girl, age 7 years). In contrast to the other prominent themes within mental health/emotions, many participants described happiness in the youth's future. In one parent's past conceptualization of the future, she described first learning about her child's transgender identity: ". . . when we first went down this road, you know, it was harder to picture [child] as happy as she is right now" (mother of a trans girl, age 14 years).

Relationships. Relationships included prominent higher order codes such as *friendships* and *caregiver-child relationships*. Participants often described friendships in terms of acceptance and rejection, especially in relation to being out as transgender. One mother of a trans boy, age 10 years, described that her child was "worried about how his friends were going to react" in the short-term future when he first came out as transgender. Another youth participant anticipated friendships in the short-term future of college, ". . . you don't make friends because you're trans . . . I don't really want the fact that I'm trans to decide whether someone's going to be my friend or hang out with me" (trans boy, age 18 years).

The theme of caregiver-child relationships was also prominent when considering the youth's future. In past conceptualizations of the future, some participants described future thoughts about these relationships when the youth first came out as transgender, ". . . [child] and I weren't gonna have a stereotypical father-son relationship . . . I felt a loss for that" (father of a trans girl, age 8 years). Other caregivers described their relationship with their child going forward into the short-term and long-term future, as in one parent's narrative: ". . . hopefully [child] will keep our relationship strong, and [both parents] are trying to be as open as we can about anything so that [child] knows that she [pronoun used by caregiver] can . . . come to us" (mother of a trans boy, age 10 years).

Approaching the Adjustment and Expectations

Barriers to envisioning a positive future anticipated by family members also affected experiences in two additional areas: approaching the adjustment and expectations. These two themes were grouped together because they both represented cognitive processes related to how the participants thought about the youth's future.

Approaching the adjustment. Approaching the adjustment included prominent higher order codes such as *decision-making about being out*, *is my child really transgender?* and *uncertainty about the future*. Decision-making about being out was typically described in relation to different contexts, such as future school, employment, and extended family gatherings. A mother of a trans boy, age 9 years, described moving to a new town in relation to her son's short-term future:

I asked him: "How do you want me to enroll you in this school? Do you want me to enroll you as who you were before or do you want me to enroll you as who you are now?" And he says: "I only want to be known as [child's chosen name]. I only want to be known as a boy. I do not want to be known as the boy who used to be a girl. I do not wanna have to answer questions because people do not understand."

Many caregivers questioned whether their child was really transgender. This was more typical among caregivers of younger children who had recently come out as transgender, than it was among caregivers of adolescents who had been out for some time. A mother of a "girlish boy," age 8 years, described this uncertainty in thinking about her child's short-term and long-term future:

. . . he will say technically "I'm a boy," but . . . one day there was just me, my younger sister, and him and he put his arms around us and was like "I guess it's just us girls now." So I think he really identifies and whether that's just a super sensitive new age guy or maybe he's just really meant to be a girl. I do not know.

Uncertainty about the youth's future was expressed by both youth and caregivers, but primarily by the latter. The youngest youth participants often had not thought about their future yet, as one youth participant said, "I don't really think about it that much" (trans boy, age 10 years). But for some caregivers, the uncertainty held more weight and was sometimes described as "scary." A father of a trans boy, age 15 years, described this process in thinking about the long-term future:

. . . when I start thinking about the future I get very scared, and I do not know what it holds but I'm sure we'll meet it head on and that's all I can say. Yeah, I really do not know, it gets me nervous.

Expectations. Expectations included prominent higher order codes such as *ideal expectations* for the youth's future, *expectations for romantic relationships*, and hopes for the future regarding *societal views of LGBTQ issues*. Ideal expectations for the youth's future were often described by caregivers as past conceptualizations of the future in the time period before their child came out as TGN. One parent described how her expectations for her child changed when her child came out as transgender: "He was gonna be top 5% of his class, do anything. The world was open to him with all his talents and that just went out the door . . . I felt like the rug was pulled out from under me" (mother of a trans boy, age 18

years). A trans girl, age 15 years, described ideal expectations for her long-term future in terms of life goals:

. . . to carry out my transition, get the [gender affirming surgery] and just become fully female . . . it's gonna be kind of strange after that 'cause I would have accomplished my quest and I'll be like, "I do not know what to do now!"

Expectations for the youth's future romantic relationships were discussed by both youth and caregivers. These expectations related to the timing of romantic relationships (e.g., waiting until the youth is older), being out regarding the youth's TGN identity, and finding romantic partners who are accepting. As one parent described, in relation to their child's long-term future: ". . . you want [child] to have success with relationships, that sort of thing . . . the typical human experience, marriage and that sort of thing" (father of a trans girl, age 13 years). A youth participant talked about how his gender identity might affect romantic relationships in the short-term or long-term future: "If it does, then they weren't the one for me" (trans boy, age 18 years).

Participants' hopes for the long-term future regarding LGBTQ issues in society often compared transgender rights to LGB rights, and were generally optimistic. A father of a trans boy, age 15 years, compared transgender issues to LGB issues:

. . . there's a lot more paths than there used to be . . . there's a lot of acceptance that was not there even a year or two or five years ago, much less 10 or 20 years ago . . . I think [transgender] is the next frontier in acceptance.

As another parent said, "I think that this is going to help the whole world think about gender in a different way that is more about what we feel inside" (mother of a trans boy, age 10 years).

Identity

Barriers to envisioning a positive future anticipated by family members also affected experiences related to the youth's transgender identity. Identity included prominent higher order codes such as *authenticity* and *personality and behavior*. Participants described the concept of authenticity in terms of the child being who they are. One parent described the youth's coming out process, regarding their short-term and long-term future: ". . . she's figured it out and it makes sense to her and that's who she wants to be moving forward . . ." (father of a trans girl, age 13 years). Another parent described hoping that the family can contribute to the youth's authenticity in the short-term or long-term future: "I feel hopeful that we are going to be able to do the things that are going to help [child] feel or to present and look like the boy he feels inside, and the man" (mother of a trans boy, age 10 years).

Personality and behavior arose in participants' narratives primarily when caregivers described the youth in ways that were not necessarily gendered or related to the youth's transgender identity (e.g., "popular" or "compassionate"). At times, descriptions of the youth's personality and behavior were related to gender or to the youth's transgender identity, as in one parent's description of their child's long-term future: "I think [being transgender] is going to grow his confidence and compassion for people. I think he's going to be a kind of man that's very nurturing and very wild and energetic" (mother of a trans boy, age 10 years).

Institutional Factors

The three thematic categories of (a) acceptance/support, mental health/emotions, and relationships; (b) approaching the adjustment, expectations; and (c) identity were all related to thoughts about the youth's future in the short-term, including institutional factors and health/interventions. Institutional factors included prominent higher order codes such as *camp*, *pre-college school*, *college*, work-related issues in the *youth's future employment/ career*, and specific careers for the youth in the *youth's future employment/career*. Many caregivers of younger youth anticipated experiences related to camp and school prior to college. One parent described her feelings about an upcoming camp experience for her child in the short-term future: "[Child] just found out today that [the school] is not gonna let him room with boys for the 6th grade camp. And so, we are so disappointed" (mother of a trans boy, age 11 years). A youth participant described anticipating bathroom use at school: "I wouldn't even want to think about what would happen at school if I tried to use the guy's bathroom, which I am not allowed to until I physically transition and have bottom surgery" (trans boy, age 15 years). Many of the older youth anticipated college and their future employment in the short-term future. One youth participant described an upcoming move for college: "I'm going to a new school in a different country and I don't know anyone, I don't really want to be known as the trans kid anymore" (trans boy, age 18 years). Another youth participant anticipated challenges with employment in their short-term future when asked by the interviewer how they thought their transgender identity will affect their future: ". . . finding jobs, 'cause like, most people don't accept it . . . Hopefully for the future, for me, I'll be able to have a good job, education, and everything" (trans girl, age 13 years).

Health/Interventions

Health/interventions included prominent higher order codes such as *feelings about gender affirming treatment* and *professional help*. Discussion of gender affirming treatments was common among the participants. Caregivers expressed a number of different emotions and feelings related to their child undergoing gender affirming treatments, including fear, concern, sadness, nervousness, and feeling overwhelmed. One parent described feeling overwhelmed when faced with gender affirming procedures that were potentially in her child's short-term future: "I think going to the daylong conference and learning about the surgery, timing, and the blockers and all that stuff was overwhelming" (mother of a "girlish boy," age 8 years). Another parent described feeling sadness related to his child having gender affirming surgery: ". . . there's a sadness there because you feel like, you know, your body's perfect already, I'm not convinced your body's gonna be better when you alter it surgically" (father of a trans boy, age 17 years). Many participants had already sought professional help related to the youth's TGN identity and anticipated more professional help in the short-term future, primarily in the form of mental health therapists and doctors. As a mother of a "girlish boy," age 8 years, said, "I feel like my hope is that he will be okay with who he is and as a family we will feel like we'll find the right care providers to help us make whatever decision we will need to make."

Discussion

The aim of this study was to examine how TGN youth and their caregivers perceive the youth's future in light of the youth's gender identity. Two previous studies have examined how transgender adults consider aspects of their future: anticipated stigma (Golub & Gamarel, 2013) and potentially traumatic events (Shipherd et al., 2011). However, these perspectives provide a snapshot of specific types of anticipated future outcomes for transgender adults, rather than examining how transgender youth think about their future in general. This study is the first of its kind to explore the future perspectives of TGN individuals from both youths' and caregivers' perspectives.

The theme of societal factors was particularly important as these factors impacted all of the constructs throughout the conceptual model. Research on social comparison indicates that the future is constructed through anticipated outcomes as compared to similar individuals (e.g., Buunk, 1998; Crosby, 1976). Findings from the current study replicate these concepts; youth and caregivers do not have access to many role models, but the ones they do have will shape hopes, fears, excitement, and worry as the youth continue through their identity process. TGN youth and caregivers in the current study grappled with how to fit in as the youth's gender identity develops, with worries primarily revolving around appearance and gender expectations. West and Zimmerman (1987) contend that individuals are constantly "doing gender," in that humans intentionally or unintentionally participate in gendered situations and perceptions that reinforce gender norms. Schilt and Westbrook's (2009) research on gender norms and how transgender adults "do gender," indicates that transgender individuals use cisnormative ways of being gendered to feel normal; however, this research was primarily focused on how transgender adults' sexualized relationships are gendered. The current study extends previous research by examining gender norms that may exist for TGN youth and how caregivers may reinforce these norms.

Barriers to envisioning a positive future that were described by youth and their caregivers were directly related to how families perceived societal factors. Although research on future perspectives indicates that youth share their fears and concerns related to the future (Seginer, 2009), the individuals in the current study reported barriers that most other youth do not encounter. Research with transgender youth indicates that experiences of discrimination (Grossman & D'Augelli, 2006), difficulty with the health care system (Vance et al., 2015), and challenges with policies and legal issues (McGuire et al., 2010) are common. In the current study, anticipated discrimination was based on two factors: (a) experiencing discrimination first-hand, thus setting the stage for future experiences, and (b) hearing about other TGN individuals' experiences of discrimination. Previous research with transgender individuals indicates that anticipated negative events and emotions fuel perceptions that all interpersonal interactions are going to be difficult (Budge, Orovecz, & Thai, 2015); however, this anticipation can be both protective and harmful (Link, Wells, Phelan, & Yang, 2015). Participants in this study also described issues in the foreseeable future with insurance companies, such as affording health care-related costs. Although this is a common concern for many families, the burden of covering medical expenses that are not covered by insurance can be financially devastating (Sanchez, Sanchez, & Danoff, 2009). Even if all insurance companies agree

to cover transgender-related health care in the future, the stress of anticipating navigating insurance coverage remains.

While many of the future perspectives in this study were rooted in stress and worry as a result of anticipated barriers to envisioning a positive future, TGN youth and caregivers were also hopeful about laws and policies changing for the better. This finding is in line with research that indicates that transgender individuals have positive responses (momentum, hope, and positive emotions) to seeing positive changes in popular culture and laws, which in turn fuels additional change and hope (e.g., Budge et al., 2015; Hines, 2007). This finding is also in line with future perspectives research that highlights hope in contrast to fear (Seginer, 2009). In the current study, caregivers described hope for continued connection among family members and openness regarding unknown future experiences. Retrospective research indicates that transgender adults wished that their family members had reacted in many of the ways the caregivers did within this study (Riley, Clemson, Sitharthan, & Diamond, 2013).

Upon acknowledging anticipated barriers to envisioning a positive future, three interpersonal themes arose, which were grouped together in the conceptual model: *acceptance/support, mental health/emotions,* and *relationships.* A common finding from many psychological studies regarding transgender individuals includes the importance of social support (e.g., Budge, Katz-Wise, et al., 2013; Bockting et al., 2013; Nemoto, Bödeker, & Iwamoto, 2011). The findings from the current study are no exception to this common strategy of coping with anticipated barriers. One finding that deviates from previous research is the concept of caregivers wanting to help their child counter the barriers that the youth may experience in the future, specifically giving the youth skills to deal with future adversity. The caregivers from this sample were overwhelmingly supportive, which suggests that there may be a connection between initial family support and preparation to handle difficulties. Previous research with racial and ethnic minority populations indicates that this type of preparation for youth with minority identities is an essential component of coping and resilience (Hughes & Johnson, 2001; Phinney & Chavira, 1995).

In contrast to the interpersonal reactions to barriers listed above, there were two themes that described cognitive processes that were related to barriers to envisioning a positive future: *approaching the adjustment* and *expectations.* All of the TGN youth and caregivers described their thought processes as they were planning for the changes ahead. For example, participants indicated that there were many future decisions to be made and there was uncertainty about identity and what the future might hold. This finding follows initial scholarship on future perspectives describing how uncertain or pessimistic thoughts occur for "socially deprived groups" (Trommsdorff, 1983). The *expectations* that were described in the current study were primarily focused on the family's value system (e.g., expectations for romantic relationships and independence) or societal expectations (e.g., coming out, sexual orientation). Previous research related to transgender individuals and expectations has focused on transition-related outcomes (e.g., Katz-Wise & Budge, 2015); the current study extends this work to describe expectations beyond those related to gender transition.

The fourth theme related to barriers to envisioning a positive future was *identity.* Much of previous research conducted with transgender youth has focused on the youth's current transgender identity (e.g., Burgess, 2000; Grossman & D'Augelli, 2006;

Pollock & Eyre, 2012); many of the future processes in this study follow the same themes from previous research. As with the current study, previous studies have noted that in the face of barriers, allowing oneself to be authentic regarding gender identity can be incredibly empowering (Singh et al., 2014). As well, research on cisgender youth and future perspectives indicates that confidence about hopes and plans materializing are related to identity processes, thus assisting with exploration and commitment of identity (Seginer & Noyman, 2005). The current findings add to previous research by highlighting that youth and their caregivers wanted the youth to find their authentic self, while also maintaining other nontransgender aspects of their personality and self.

The participants in this study also described shorter-term future aspirations for youth. TGN youth and caregivers described worries and hopes for how the youth will navigate institutions, such as secondary school, college, and camps. In the model, future perspectives related to institutional factors were directly related to interpersonal and cognitive processes associated with youths' transition and identity experiences. Although institutional factors can be, and are, a part of these experiences, the youths' future was typically framed logistically (e.g., negotiating bathrooms). However, it was common for youth to express hope for being stealth by being in environments where no one had prior knowledge of their transgender identity.

Limitations and Future Research Directions

There were several limitations to the current study. First, we approached this research question using an exploratory design and framework. As with any exploratory study, there are limitations to how participants are recruited and the generalizability of the information provided. For example, there is a wide range of developmental processes that occur from the ages of 7–18 years, particularly among TGN youth; we acknowledge that future perspectives will look entirely different for youth at age 7 years versus age 18 years. However, the amount of overlap—given the wide age difference—is telling of how close the shared experiences of TGN youth are, even with sample limitations. Future research should determine the different developmental trajectories of future expectations for youth, based on the age at which a youth realized their TGN identity. In addition, future research should quantitatively capture the differences between short-term and long-term expectations to determine the impact on life-functioning and well-being.

TGN youth and caregivers were asked different questions about perceptions of the youth's future, which may have shaped participants' responses; however, the transcripts as a whole were analyzed for future-related themes, rather than limiting analyses to participants' responses to future-related questions. Furthermore, TGN youths' and caregivers' interview transcripts were analyzed together, rather than separately. It is possible that analyzing them separately may have yielded different results; however, the themes and conceptual model that emerged from this analysis represent the experiences of both TGN youth and their caregivers. Table 2 reports the number of line by line codes from caregiver versus youth interviews, which readers

may consult for more detailed information regarding which themes appeared in interviews from TGN youth and caregivers.

Another limitation is that the majority of the families were White and upper-middle class. This sample provides a snapshot of the future perspectives of families that fit within this demographic, and is not likely to be representative of families of color and/or from lower socioeconomic backgrounds. Families of color may have different perceptions of transgender youths' futures, specifically related to knowledge of higher rates of victimization among transgender individuals of color (Grant et al., 2011); these concerns were not represented within the current data. As well, families in the current study displayed a certain amount of economic privilege; for families from lower socioeconomic backgrounds, anticipating costly gender affirming medical treatments may impact future perceptions. Future research should focus on the unique future perspectives of families who experience economic and racial marginalization. In addition, caregivers in this study were overwhelmingly supportive of their TGN child; therefore, the results from the current study may not represent families with unsupportive caregiver(s). Future research should focus on interventions that specifically target future perspectives to determine if there are ways to address barriers to envisioning a positive future and interpersonal expectations, and overcome fears regarding uncertainty and negative expectations for the future. Future research should also determine if the current model fits for families who are not as supportive of TGN youth to determine how anticipated events/situations differ based on level of acceptance.

Implications for Practice

There are several implications for counseling psychologists based on the findings from the current study. It will be important to involve all family members in mental health interventions regarding fears and hopes for the youths' future. This assessment will provide counseling psychologists with a clear understanding of the actual and anticipated barriers to envisioning a positive future faced within the family and lend to specific interpersonally- or cognitively-based interventions. For example, some of the cognitive processes that occurred in this study were related to having specific expectations related to a child's future that are no longer relevant once they identify as TGN; the adjustment of these expectations will focus on interventions that address cognitive flexibility and managing affect (such as disappointment and grief) that follow this process. In Budge's clinical work with TGN youth and their families, it is not typically clinically indicated for youth to hear all of the fears their family members have related to their future. Youth appear to internalize the stress of their family members. Instead, it might be useful for all family members to write down their fears and for the therapist to aggregate themes from the writings to assist with a family intervention. It can also be useful for the therapist to ask family members to process their fears with others, so as not to overburden each other (and specifically the youth) with concerns.

If families tend to discuss more uncertainty about how to proceed with decision-making or about the youth's future identity, cognitive–behavioral interventions geared toward trans-

gender individuals (e.g., Austin & Craig, 2015) and mindfulness-based and acceptance and commitment therapy (ACT) exercises (Gehart, 2012; McHugh, 2011) can help families cope with ambiguity and uncertainty. One intervention that might enhance planning for the future is an exercise in which the therapist outlines themes from the current study on separate sheets of paper and asks each family member to list their expectations and worries based on each theme. Then, family members can discuss coping mechanisms and how they want to work together as a family on each of these issues. This exercise can assist family members in understanding each other's expectations and derive developmentally appropriate problem solving for each family member.

The research in the current study indicates that caregivers are concerned about what will occur if a child "changes their mind" (a developmentally appropriate evolution of identity exploration); in Budge's clinical practice this is a frequent concern of caregivers of TGN youth. Much of psychoeducation focuses on normalizing identity development and fluidity in youth, and sharing findings from research indicating no long-term negative psychological effects of youth being affirmed with their current gender identity and identifying differently later. It is also useful to discuss the process of how the family wants to communicate if a youth is questioning aspects of their gender process and how the family can support and problem solve these issues. It is our hope that the current study will contribute to a new understanding of family dynamics regarding future perspectives for TGN youth, and will jumpstart a new line of research in which family dynamics and family interventions are created and researched for effectiveness.

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Note: Details and names were changed throughout these reflections to protect patient privacy

Appendix B:

The guy with the CPAP:
He was a mid 30's guy with "abnormal facies". He had some sort of chromosomal disorder if I remember correctly. But he was the friendliest guy in the hospital. His mom was always by his side during the day. He would smile every time you entered the room—and then thank everyone profusely as everybody left. He was there for right upper quadrant pain. He had symptomatic gallstones. The procedure was simple. Laparoscopic surgery was the least invasive procedure we could offer him. Even post-op he did not complain of pain and maintained a smile. He was ready to leave as soon as he could. But protocol meant he stayed in the hospital for at least another day for observation—to make sure everything was healing appropriately. He was put on his home CPAP machine—a common treatment for sleep apnea. It helped him sleep better. That next morning I came into the hospital early eager to help my team. I came in an hour early than usual to write down patient's overnight vitals for my intern. She came in earlier than I expected. I smiled, "Good morning!" She looked at me straight faced and said, "You didn't hear? George Bing passed last night." "What how?!" "He vomited into his CPAP."

One week later, my intern checked in on me to see how I was doing. While death was common in the medical field, I was still a medical student and my exposure was limited. She was the only person on my two months of surgery to ask how I was doing. She's the kind of resident I hope to one day be.

Trauma—run back to OR, open chest
The phone rings in the trauma bay, a nurse picks up the phone, and proceeds to contact everyone needed to assess the incoming trauma. My pager goes off. Motorcycle collision 10 minutes by ambulance. Time passes by quickly, the man rolls into the room covered in blood. The initial evaluation is a blur to me as I wonder if this guy is going to make it. Several people join the room. More nurses, a pharmacist. The crash cart is out. The man loses his pulse. A trauma fellow yells over the crowd "Thoracotomy tray, NOW!" As a medical student this is the most severe trauma I've yet to witness. I stand back not wanting to get in the way. See one, do one, teach one is what we say. I have yet to see one. I watch as they desperately cut into his chest to do a bedside thoracotomy, unsure of what the purpose of this is yet. What feels like seconds but is actually minutes pass by, and attending yells "Prep the OR!" We get to the OR, chest open, med students in line with sterile gloves to do internal compressions. I look at my phone and remember, I have an on campus lab I'm going to be late for. I leave the room disappointed that I could not see the case through. After all, I didn't want to be written up for professionalism.

Fournier's gangrene:

A smell permeated throughout the 2nd floor of the hospital. In a room awaiting emergent operation was a man with history of anal cancer. His cancer had torn a hole through his rectum, and he had been effectively defecating into his own flesh where bacteria were eating his insides. Desperately prepping for the surgery, I watched as nurses waived cotton q-tips covered in peppermint oil around the room. "Make sure you put some in your mask." The man is wheeled into the room and even with my peppermint coated mask, I smell his disease. He's still awake on the table. I sense his embarrassment—his defeat. His cancer had already caused him so much pain. A priest dressed in OR room garb runs in and says a quick prayer at bedside. As soon as he's over, the anesthesiologist knocks the patient out. The surgeons do their choreographed dance, unfolding drapes soon to be covered in rotting flesh. After the first cut, I step back as the stench passes my sterile gown and begins to marry the threads of my scrubs. This smell would linger in my memory for days.

My first transplant:
A kidney transplant is a fantastic operation to witness. Surgeries are strange because you initiate every operation with a semi-complex process of draping the patient, and creating a sterile field, of which allows you to depersonalize the are you are working on. Consequently I remember the procedure very vividly, but remember virtually nothing about the patient themself. The process of taking a bloodless kidney, anastomosing its vessels, and detaching a clamp to resume blood flow is such a thrilling experience. The feeling of success gives you such a high, no wonder people go into surgery.

My first procurement
During my transplant rotation, I eagerly awaited my first procurement. I'd heard stories of people flying off to distant places to collect organs. I could wait to fly in a helicopter. Notice of my first procurement arrived. It was going to be in the same hospital I worked in. Slightly disappointed, I reminded myself of the reality of the news. Someone had just died and someone was to receive their organs. And I was going to assist in this incredible form of medicine. I would also learn that the cause of death was electrocution. The person worked for SDG&E. As the cadaver, kept alive by the machines around him, was prepped I wondered about his life. A picture of his life was painted in front of me as the transplant coordinator read a letter from his wife. My eyes welled as I heard the love letter of a new widow. I imagined the two daughters they had, his laugh and smile his wife eloquently described. And as soon as the tribute was finished, the surgeons began their dance; for the best results, they had had to move quickly.

My 2nd procurement
My second procurement happened at a hospital about 20 minutes away. Awaiting the car that was to escort us over grew an excitement in me. Arriving at the new hospital was strange. We knew virtually nothing about the patient, and I knew nothing about the hospital. The comforts of my home institution were no longer there and I had to learn my place in a very different operating room. This procurement was strangely more emotionally painful than the first. Because of the

nature of the death, we weren't allowed the time and patience like the first one to read off a letter from a loved one. We had to wait a certain amount of time after the patient was pulseless and then work as fast as we could to procure the organs as the heart had effectively stopped (unlike the my initial case). This one much more fast paced than the prior, with haphazard cuts made across the body and blood spilling faster than suction could handle. I was 2nd assist, meaning I was responsible for getting elbow deep in the body and holding organs in place as using other instruments would take too long. I sat for 20 minutes with ice covering my hands. The ice causes a pain that goes away after the numbness sets in. They gave me more responsibility. After determining that the liver was not good (blood had already began clotting deep into the tissue), they went to the back table to clean up their two beautiful kidneys. They left me to close up. The responsibility felt immense to me. While the surgeons didn't need to concern themselves as there was no risk to me killing the patient, I put pressure on myself to make the body look presentable, as family may likely be seeing her prior to the burial. I got immense satisfaction with my work (trying out a baseball stitch for the first time). I quickly forgot about the morose nature of the procedure, only to be reminded when I backed away from the table to see blood all over my legs and shoe covers.

Breast milk lady and doctor dad
In my one month of ambulatory pediatrics, there was one patient, K, I saw four times. The first time was the newborn visit, just four days old. When I opened her hospital discharge summary, I was quite surprised. She was born to a 49 year old mother by IVF. Her mom was an engineer, and her father an endocrinologist. When I stepped into the patient's room, I saw two visibly stressed adults, with bags under their eyes, staring intently at the bundle of joy urging her to eat. The father, a doctor with more than 20 years experience under his belt, questioned me on all my knowledge about breastfeeding and its benefits. He was eager to do things by the book-- and he wanted that book to be evidence-based. So of course he wanted his child breastfed because that's what's "best" for a baby. A newborn baby not gaining weight was all too common in the office. We had the family return in a few days for a weight check and to reevaluate her feeding plan. By the second visit, I was sure to have all my feeding knowledge down for evidence-based father. At the K's second and third appointment, I watched the frustration grow in parallel to their tired appearance, as K was not gaining as much weight as we'd hoped.

It was at the fourth visit at 3-weeks-old that finally K was gaining weight. The sense of relief manifested in tears in the mother's eyes. I really cherished the fact that I felt like I was treating more than just the patient; I had the opportunity to work with the family as a whole. Parents bring an interesting challenge to pediatrics and I really found myself enjoying getting to know the parents and their struggles as well as working with the kids themselves.

Seeeing my newborn in outpatient peds

Tina Forester was 38 weeks pregnant, and in labor. It was my first day on my obstetrics rotation. I helplessly followed my family medicine intern, he told me to periodically check on Tina to see how she's doing. I looked at my watch and tried to poke my head in every 10 minutes. Periodically, my intern would come with me to see how dilated she was. Before we knew it, she was nearing the final stages of labor. She birthed a beautiful baby boy. Forester, Boy: 0 days old is what the chart said. Charts are made prior to birth so "Boy" is just a placeholder for his future name.

Six months later, I'm searching through the chart of my next patient: Thomas Knok. I read that he had a healthy birth. He was here for his six month well child check. I convince myself that I'm ready to see the patient and head to his room. I open the door to see Tina Forester there. Turns out she named the child Thomas and he kept his Dad's last name. My heart warms as I hold the six month child I helped birth. Continuity is so important to me.

IUFD ☹

I'm halfway through my OB-GYN clinic rotation. My resident preps me for the next patient. "She's 16 years old and only started seeing us a few weeks ago, but she's at 28 weeks gestation right now." I enter the room and obtain my history like I traditionally do. Most of my questions come off a template I can pull up from my computer. "Any bleeding? Any headaches, or blurry vision?". Everything seems pretty normal. "Are you doing fetal kick counts?" The girl dips her head, and smiles shyly. I know that usually means they want to say yes, but it'd be a lie if they did. I tell her that she should do them every night and give her instructions on how to do it. She tells me she feels the baby move all the time. The last time she felt him move was this morning. I remind her that fetal kick counts are the best way to help us know if something may be wrong. I measure her belly, it's the appropriate size for gestational age. I pull out a Doppler probe and try to listen for the baby's heartbeat. I'm new at this and have difficulty finding it. I tell her that I'm new and I'll just grab the resident. The resident comes in and smiles, asking how everything is going. She asks many of the same questions I asked just to cover her bases. She pulls out the Doppler probe and tries to find the heartbeat herself. No luck. She says this happens all the time, and the baby could just be turned in an atypical way. She rolls in an ultrasound machine. She's quickly able to visualize the baby. My heart drops, and I try to hide the pained emotions I begin to feel. I look at the resident, who has a stone-faced smile. I bet she's good at poker. She walks out of the room, telling them she would like to talk to her attending first. We step out together and discuss our findings. There was no heartbeat. The attending steps-in, and checks the ultrasound herself. Afterall, you can't deliver such terrible news without double checking. The attending looks at the family and says, "I'm so sorry to have to tell you this, but your baby's heart is not beating—he is no longer alive." My brain recalls the letters IUFD—I had read about that before. Intra-uterine fetal demise.

When a woman turns me away at family med clinic

Part of the fun of seeing patients in an outpatient clinic is getting to review their chart, and preparing yourself before meeting them, such that you know enough to ask the right questions, and can prove that you are smart enough to at least know somewhat of what the patient is going through. The ultimate disappointment is when a woman in an outpatient clinic feels uncomfortable with a male patient and sends me right out the door. It's a frustrating experience, but one that ultimately kept me from going into OB-GYN.

Manic condescending woman who fires Ben.
In family medicine you see a wide range of patients, including your fair share of psychiatric patients. In one instance, as a junior medical student, I participated in an interview alongside a senior medical student. The patient was bi-polar with a history of shopping for doctors. Several of her prior notes were from frustrated doctors describing how difficult it is to work with such a stubborn woman. I still remember the visit 2 years later. She controlled the room using condescending words. She set the tone by asking what school's we went to. Ben responds truthfully admitting he went to Harvard. This sets off a 20 second tirade by the patient who spats a few prejudiced words about Ben. She calls him smug and orders him to leave the room. Uncomfortable with the situation, I excuse myself as well.

Alternate vaccine woman
A mother tells me she's rather not vaccinate her child as her child has gotten plenty already at prior visits. The scientist in my is screaming at the top of his lungs, wanting to appeal to her intelligent side using data and what we know from studies. The realist in me hesitates spouting off knowledge with the understanding that some people can't be convinced. I asked a few questions trying to understand her perspective. Frustrated, I moved on after reinforcing the positives and necessity of vaccines. Later my attending saw the patient and his mother. I watched how he carried himself. He had great confidence—something I lacked, and something necessary to persuade an uncertain mother. 15 short minutes later, that little kid was crying as a needle approached is upper arm. The level of persuasion that one learns from years of practice is why I accept my place in the medical field—I just have so much more to learn.

Drunk driver
The trauma room is a mess. Three of our four bays are occupied. Another page comes in. Motor vehicle accident vs pedestrian. We were getting two people: a driver, and the person she hit. I remember the face of the driver. She had reportedly been drinking. I would later find out from her victim's family she came barreling down a street at night with her headlights off. Two people were crossing the street. One of them entered the trauma bay in critical condition. I wondered how the other faired. Later that night I would find out: Dead on arrival. I watched hysterical driver, blood all over her face, tears mixing in. Having lost two of my friends to a drunk driver months earlier, I cautiously studied her face. A mix of anger and pity filled my heart. She'd done the unspeakable, and now 3 lives were ruined—many more

changed forever. I quickly imagined the pain the victims' families would endure. And then I continued to help with her trauma assessment. One of the final tasks was to draw blood from her femoral artery. The surgeons allowed me to do that. She complained of pain as I poked her. We drew several vials of blood as protocol called for. Later we would find her blood alcohol levels.

4 months later, I arrived at her indictment hearing to testify that I correctly drew her blood, so that the results of her blood alcohol level could be admitted into evidence.

My face laceration repair
The trauma bays were busy. The interns on service even busier. One poor guy had been mostly cleared after a bad motor vehicle accident, but he still had a gash that required stitching on his forehead. As a medical student, we typically need to be observed during the entirety of any procedure we partake in. You know, just in case any of the million things that can go wrong actually do go wrong. I prepped my procedure area as one would do prior to any procedure. I got everything I needed and was confidently ready to get started as this was maybe my 10th time suturing. My intern, running around wildly trying to attend to the 2 other traumas, the 20+ patients on the floor, and the needs of residents, fellows and attendings, was difficult to get a hold of. Finally I got her attention. She looked at my workplace and she told me okay you can start. I administered the lidocaine—which despite its purpose to numb the area—is actually the most painful part of the procedure. After I through my first suture my intern smiles, asks if I can handle this. I half-confidently put on a smile and report yes. I'm immediately left to finish the rest of the procedure. I finish proud of my work, hoping I'll have minimized scarring. I walk away and imagine the many ways that could have gone wrong. I shrug it off and proudly report to my intern that I finished. They say, "okay".

"Can I see the plastic surgeon?"
I had a geriatric patient in the trauma bay for "fall on Plavix". He had a gash on his face. The wife, a former nurse, demanded they see a plastic surgeon for his inevitable stitches. Having been there for only a week, I already knew how this would go. A plastic surgeon would send down a surgical resident, not unlike the ones we had on service, to do the same work. And that's what happened, and the patient was satisfied with the work.

The child I did not do stitches on
My latest stitching memory came in the throes of the children's emergency room. The patient I was following had run into a doorframe. He had a gash over his left eyebrow. At last, after 3 long weeks, I would get to do a procedure, something I was promised I'd have many of during my rotation. The kid was maybe 3 years old, had only a few years experience of walking to know he shouldn't run head first into a door frame. The child was scared. Any examination of the wound prompted crying. My attending informed me we would need to strap the child down in order to perform the procedure. We used a papoose board—something with fabric that

wraps around the child's body and forehead to prevent any movement. As I watch the strapping process with the child screaming and thrashing—I report to my attending that I do not feel comfortable doing stitches on a screaming child. My attending tells me they understand and has the resident do it instead. Disappointed in myself, I'm still able to watch the trauma in the child's eyes as the resident goes at it.

Sign language Patient
I know some sign language. When I see a deaf child or patient, I get excited that I'm able to get a little bit of practice in. I remember walking into a room to see a 3 year old kid and her mother. Mom had been learning sign language alongside her deaf child. I was able to get much of my history from a hearing mother, but my opportunity to communicate with the child was not lost. The child's eyes lit up as she excitedly told me her sign name. It was that moment that made me appreciative of how easy it is for me to communicate with those around me—that I live in a world that caters to my privilege of speaking the local language and my ability to hear.

The patient I spoke poor Spanish to
On my busy transplant rotation I had the unfortunate request of an attending to please translate Spanish for my team. I told them my experience with Spanish only lasted me through high school. "Good enough," I was told. Frustrated, I went into the room and with a shaky voice introduced myself in Spanish. I went back and forth trading my broken Spanish for what I thought were proper English translations. We were out of there in less than 2 minutes, but for me it was a lifetime. I spent the next many hours thinking about how much we learned in our first two years about cultural humility. We spent so much time trying to be aware of others' cultures and languages. We were taught that a medical interpreter was the only proper way to speak to a patient whose language you do not know. I thought about speaking up— about telling my residents and attendings why what they had me do was not okay. The 3rd year medical student in me decided to bite his tongue, suck it up, and not say anything. It's something I still think about, and still regret. I do know that this experience has informed my personal practice. Never will I put a student or other person through that experience. It's not fair to the student or the patient.

My Vietnamese patient
I worked at a free clinic during undergrad in an area with a heavy Vietnamese-speaking population. It was the day that we were short Vietnamese interpreters that I really realized my regret for not learning my parent's native language. Every 15 minutes a student or doctor would see my name tag and ask urgently "do you speak Vietnamese?" Others were more forward and would call at me, "Hey we need you to interpret in here!" This feeling was not lost on me when four years later as a 3rd year medical student, I had my own Vietnamese patient. Embarrassingly, I'd set up a MARTI as my patient and their family would ask me questions. I would respond in one of few Vietnamese phrases I know, "I don't speak Vietnamese."

Mr. Simpson

It's very satisfying being able to see a person physically get better. It's why surgery was such an attractive field to me. You do a procedure and shortly after see the results. There was one patient who needed a new liver. With bilirubin levels nearly maxed out he was a bright yellow color. His brain, not functioning like a normal human being. We gave the man a cadaveric liver, and slowly I watched as his skin returned to a normal color. The best feeling is when you see a patient you thought was a goner finally leave the hospital a healthy person.

The girl who needed a liver

On my transplant rotation, we followed a girl who was about my age. She had hepatic encephalopathy do to alcoholic cirrhosis. She had drunken her liver to death. Her sister, almost always by her side, would be the one we would communicate with. I remember watching her brush the patient's hair as we answered her questions. The patient's yellowing skin made her look less human as the days passed. Looking at her room covered in pictures detailing her life prior to the hospital made me wonder about her life. One of her most difficult days was when we walked in on her smelling the alcohol sanitizer in her hands. This concerned the team—they didn't want her to lose a new liver to alcoholic cirrhosis as well. I remember the brief debate on whether or not to take her off the transplant list. I left the transplant service with her still waiting for a liver. A few weeks passed by and I wondered to myself if she ever got her liver. I googled her name out of curiosity to see if she may have been in the news. A "We Love Katie Peters" facebook group popped up. The most recent post was from her sister.

"Today is the day that Katie has left us. She has gone peacefully. She has fought so long. We are very sad to see her go. We will miss her beyond any words. I know I will always have a piece of me gone. Lots of love to you all and thank you for being there for the support."

The girl who wouldn't die- a biographical discharge summary. Death note.

Tammy was a cystic fibrosis patient who was no stranger to the hospital life. When I went onto service she had already been there for two months post-transplant of lungs, and liver. And still, her organs were all failing her. Her liver was shredded. Her kidneys had given up. She was on continuous dialysis and CPAP. She was hanging on by a thread—b ut a very thick and tough thread. She held on as I listened to doctor after doctor talk about how death was inevitable. Many discussed the wasted hospital resources on what was sure to be death. When I went off service, I switched to another surgical rotation that would frequent the ICU where she was staying. It was an odd day when I walked by the room she had been in for months and suddenly there was a new occupant. Curious, I asked around. I found a resident with her chart open and asked what happened. "She finally went…" I watched as he copied the pages long discharge summary that had been written as resident after resident cared for her. He pasted all of the information into a death note--a formality to document all that had happened leading up to her death.

Appendix C:

Two years ago, I lost two friends to a drunk driving accident, with a third suffering a traumatic brain injury—he was hospitalized for weeks. The last two passengers were in and out of the hospital in just a few days. There is a sense of responsibility one feels when in their head, they think if they had changed just one thing, their friends would still be alive.

In the days following the accident, I had some of those feelings. One of my late friends, Madison, was the designated driver taking a car load of people home from a party to celebrate the beginning of our third year of medical school. I hosted that party in my home. My thoughts were an amalgam of "what if I didn't host that party?" "What if we ended it earlier?" "What if we just had everyone stay at our place?" "What if I were never friends with them?" "What if I never went to this school?" Deep down inside I know there were many small things in my life that could have kept them off the road for those fateful moments. It was the comfort of friends who helped me reframe my thinking—"You can't live thinking you are responsible for these things" "None of your decisions were the wrong decisions no matter what the outcome" "It was the responsibility of the driver to not drive while under the influence."

It doesn't stop me from thinking, "what if?"

It took months for me to return to a sense of normalcy, and to stop having those thoughts. It took me even longer to stop constantly thinking about that accident.

In the fall of that year I was on my surgical rotation—always moving, always tired. It helped me to forget as there were so many other things to worry about. On my surgical services, people's lives were often hanging on by a thread.

During my first nigh shift on the trauma service, I witnessed mayhem. I must have seen at least 15 people come through the trauma bay that night. It was my most memorable night of my third year. There were a handful of pedestrians hit by vehicles. Multiple intoxicated people arriving for unthinkable reasons—a woman fell off a balcony at a party, a man covered in glitter and blood found unconscious at a rave. One woman that night stood out to me. She was in a state of shock—half crying half surprised with her face covered in blood. She came in as a twofer. "MVA vs peds." That's code for car hit a person. The woman was the driver, and another patient the pedestrian. As their story unfolded I discovered that there was a third person, also a pedestrian. Dead on arrival.

My body full of adrenaline and emotions thought long about the care this woman was about to receive. As a future doctor, I knew that no one is to be turned away, and you sure as hell better give someone the best care you can give. I watched as the team around me treated her like any other patient. I watched a nurse comfort her. Her wailing in pain and crying for the terrible mistake she had made. My role as a medical student was to take notes of the trauma survey. When it came time to draw blood, they asked if I wanted to do it. A surgeon previously told me a medical student should always says yes when asked if they want to do something. I had done several femoral sticks before. I was very familiar with the procedure. I know exactly

what I did, as my team watched my move. The intern, Guy, was giving me tips along the way.

I remember much of that night was spent juggling the completely occupied trauma bay. I remember watching the pedestrian hanging on for their life—in a far worse condition than the drunk driver. I remember in my tired state imagining the incident. Family members who witnessed the incident painted a picture for me. The headlights were off, and she came tearing down the street. My thoughts wandered to my previous constructed imaginations of how my friends died—entering the freeway ramp, a wrong way driver racing towards them. I imagine screams. There's always screaming when I think about it. I always have to shake myself out of those thoughts to return to the present.

It wasn't until much later in the night that some of her blood tests came back. I don't remember her alcohol level, but I do remember people on my team playing "guess how drunk"—the result being well beyond the legal limit to drive.

My night on call was long, but it was rewarded with the rest of my Saturday off, followed by my weekly day off Sunday. The events of that night were easier to digest, as those patients weren't people I knew intimately. I had many patients throughout my surgical rotation so I didn't think of those patients often.

Months later I got a page from the hospital's risk management department. In returning the page, I had discovered that the district attorney had sent them a subpoena for my appearance in court. They wanted my testimony in the care of the patient. In contacting the district attorney, I discovered that the defendant was trying to challenge the legitimacy of my blood draw in hopes of getting the blood

alcohol level thrown out of evidence. The last thing I wanted to do was to testify in a court proceeding aimed at sending a drunk driver to jail. I agonized for several nights about what I'd say, what questions they would ask me. I questioned my memory of the night's events. I had seen so many patients over the months. It amazed me how one woman's face could be so engrained in my memory.

Two days before one of my shelf exams I was arrived a San Diego Courthouse. I checked in and sat among other people called to testify in my patient's court appearance. Some were family members, others bystanders. I heard stories of the Lauren, the mother and wife who died. I met the man who survived the accident. I sat quietly in my corner reading my books on obstetrics and gynecology—anxious for both the impending trial, and the shelf exam just two days away.

This was my first time testifying in court. I don't know if it was the nature of the case, or just the act of testifying, but I felt a sense of nervousness as I entered the court room. Family members, and news outlets eager to report on the case packed the room. Everything was strangely quiet with many eyes on me. The questions that soon came were haphazard. They questioned my knowledge of what I was doing when drawing blood. There were specific questions about my knowledge of the chemicals in the tubes I collected. Anti-coagulants? Preservatives? There were a series of "I do not know" answers. They asked if I used an alcohol pad. I distinctly remember no—we used povidone-iodine—the sudden realization dawned on me that this was likely a reason to not use alcohol prep pads.

The one question that I reflect back on the most was one of the first "Do you recognize Kasey Glen-Elberg, the defendant in this case, and if you do please point to

her." I was surprised by my ability to recognize someone I hadn't seen in months—

that the hundreds of patients I had seen since didn't muddy my memory too much.

But as I pointed at her, I saw something different. She was sullen, her eyes full of

remorse and regret. As my index finger faced her direction, I pictured the tearful

shocked face I remembered from that fall night. It's amazing how in that moment

the anger I felt towards a drunk driver, turned instead to sympathy and pity.

Appendix D:

Vaccine Refusal

From a medical student perspective, vaccine refusal is a difficult endeavor to tackle. As a scientist would, we hold our data to high standards, and believe research holds a strong power in the world of healing. As care-givers, we want to use that data to improve health outcomes. Vaccines are something almost universally accepted among health care professionals.

As a medical student, we play this fine line of being that care-giver but also being a trainee. We try to balance our belief in the system, while also trying to remain humble learners. When it comes to talking to patients about vaccines, I've found it difficult for unexpected reasons.

For me, vaccines are a foregone conclusion—why wouldn't someone want their child to be protected from awful disease. But in the medical office, I play the role of trainee—where I need to step back and accept certain things. For example, patient autonomy (and in this case, parent autonomy) is to be respected. A person has their right to deny medical care, and make medical decisions for themselves (and children).

During my outpatient clinical rotation I encountered one such family that did not want to receive vaccines that were due at their child's 4-month visit. They didn't like the sound of injecting their child's body with something so foreign to them. They informed me they had been reading a book that detailed the dangers of vaccines. I understood their concerns and asked if they would like to talk about any misconceptions they may have about vaccines, and they quickly shrugged me off and asked not to discuss further. I allowed patient autonomy to persist and continued on with my visit. The last thing I wanted was for a patient to fire me. When presenting my patient to my attending, I was greeted with an eye-roll, followed by "one of *those* parents".

I was surprised about my attending's ability to hide his disdain in the following patient encounter. He readily printed out some information about vaccines to give to the parents. He entered the room and handed it to them. He started talking about all the benefits of vaccines, and tried countering the patient's conclusion about vaccines. What I noticed was he didn't simply use facts and logic to win out the conversation. He used a combination of logic/reasoning, but also appealed to an emotional side, and an ethical side. He used his power as a doctor to tell the patient this is not a battle he likes fighting, but that he does it because he's seen countless times how vaccines are a benefit to the patient—that the doctor wants what the parent wants: what's best for the child.

Logos, pathos, and ethos. That's something I've been hearing from both the medical and the writing field. It's 3 important areas of rhetoric people should employ to be persuasive. I felt like this doctor mastered this art whether or not it was intentional.

It was later that day that I encountered a mother who did not want to give her teenage son the HPV vaccine. One of the "newer" vaccines, it has had challenges likely due to it's relation to it's common method of transmission: sex. Although a different argument was to be had with this parent, I tried a similar approach. Trying to find their concerns—combatting it with my knowledge of the disease, and similarly trying to side with the patient in a way that acknowledged I don't have a personal stake in the vaccine—but that I do care about the patient. I can acknowledge the fact that this parent was not the same as the previous parent, and that she may have been persuaded because she didn't actually care whether or not her son received the vaccine. But I do know that whatever I said worked.

For me it was an interesting opportunity to see both my failed and successful attempt at discussing vaccines with a parent. As a medical student, I was humbled by the opportunity to learn from a seasoned attending. I hope to continue learning and develop my persuasive-doctor style as I continue to practice medicine.

Appendix E

"What could we have done differently?" | Thoughts on Institutional Forgetfulness

It is a question we often ask ourselves: "What could we have done differently?" Whether it's when we've made a mistake, when an attending gives negative feedback, or when something unexpected happens, it helps us learn from our past. I find this to be an important question, and one that often guides me in medicine. Mistakes happen, and the process of a good medical education is full of trial and error. But how do we apply this learning to something bigger than a single person, like an institution or a school?

I visited a friend, also a medical student, in New York this past month. The day of my arrival, she informed me of some grave news: "A classmate of mine committed suicide this morning." My heart ached for her school. I asked her if she wanted time and space to herself. She figured company would be good. Our lives paralleled one another– a year prior my school experienced a similar loss, and I tried to relate. But in those instances, it's impossible to know exactly what a person is feeling.

As an outsider, I watched the tragedy of that morning unfold. My friend told me how their deans sent an email out to the school telling them someone had died but named no one. This caused a strange turmoil in her class given it could have been any member of their class that they lost. It was in whispers that many of her classmates found out who had passed and what had happened. The nameless email was just one of many things students felt the school had done wrong. Just hours later, school administrators held a student meeting. With just hours to process the day's events people were already arguing, speculating the cause of this completed suicide, putting blame on the school and administration for unnecessary pressure the student likely faced. This meeting occurred while emotions were high; people were asking, "What could we have done differently?"

This event forced me to reflect on how my school handled its similar situation. I recall administration sending an email out, naming the passed student. Our school's administration similarly held a meeting where we expressed our grievances with school stress, and need for mental health support. We were offered counseling, and made aware of the mental health resources available to us. Similar to my friend's experience, students here were angry, upset with how the pressures we face can

lead to things like this. But then months passed, and like lots of things in school, the passion that fueled concern for mental health and what had happened faded behind us.

I, too, asked, "what could we have done differently." Though much can be said about suicide, and in particular physician suicide (here, here, here, and here), I wonder more about how we can institute change, and keep it relevant even after many of us have moved on. We shape our own personal knowledge by trial and error. But it's difficult for us as transient four-year-students, to maintain an institutional memory of what we can do better. Administrators may persist, but those of us at the heart of wanting to create change are only temporary pillars trying to hold up this falling ceiling. We brainstorm ways to promote suicide prevention. We say, "this is how things should be." But then we graduate, we move on, and leave future students who have not learned from our shortcomings.

In medicine, they say every patient is a teacher. In medicine you quickly realize people will die, you can't save everyone. As healers we allow those we can't save to become teachers, so that in the future maybe we can do something differently, and in the end save someone else. And in these two instances of losing our med-school colleagues, they have taught me the importance of mental health, that we need to address unnecessary stress, and we need to uncover and resolve systemic problems. But by evidence of persistent issues with higher rates of health-professional suicide, I'm not sure if institutions are remembering what they could have done differently. We need to figure out a way to remember what we have learned and not let time wear down these lessons. And unless we fix this problem of institutional forgetfulness, we will keep asking ourselves, "What could we have done differently?" Unfortunately, this is a question of which I still have not found the solution.

With a heavy heart,
Bradford Nguyen

Appendix F

It's taken me some time to mourn the election results from this past week. I've tried to balance my emotions with my desire to understand the electorate. Something so unexpected happened and I've spent a lot of time going through the many stages of grief.

My feelings have gradually changed. For some context, I am generally a socially liberal person and have spent many years fighting for the oppressed and disenfranchised. I am a gay millennial born to two Vietnamese immigrants. This past year's election rhetoric has been hurtful to me and it was easy for me to be both desensitized and disillusioned with this new democratic process. For me, it was impossible to imagine someone so ignorant to make it to the White House. I had more faith in the America I know to prevail.

Which is why this result was so hard to cope with. I suddenly realized I was missing something. I've sat in my personal echo chamber hearing everything I wanted to hear. Even me using "echo-chamber" am something I've constantly heard on social media. It's something many of us are starting to grapple with.

What I've come to realize about "the other side" is that our plight is their plight, just in a different context. Both sides are motivated by fear. There is uneasiness about what our future holds for both sides. While one side feared the racist bigotry would be unleashed, the other decided that this was not a deal-breaker. They found that their very real fears for their livelihoods were more important.

I cannot predict what the future holds in store for us. The political climate is a scary one. I hope that it in time we achieve an appropriate balance. I think that good will prevail and I hope that a desire to be better and do better will rebound from this last election.

Like many of my peers, I fear for my patients. I cannot imagine what it is like to be uncertain about one's health, or even presence. Being in San Diego, many of our patients are undocumented. Campaign promises to deport our patients and build a wall strike fear in all of our hearts. The desire to revoke health care for the many who have benefited from the Affordable Care Act terrifies me.

While I feel helpless in many ways—I do know that I will continue to fight. Physician resistance is a real thing, so I will do all in my power to protect my patients, help my friends, and protest any injustices that will inevitably come our way. I'll always remember: Do no harm.

Appendix G:

Anecdotal Medicine

I hate anecdotal medicine: "This worked for me, so everyone else should try it!" "My friend used that once and he almost died." The personality behind those who hide behind anecdotal medicine seems to be more apparent as I've been following politics a lot more closely since this last election. In the first daily press briefing of Donald Trump's presidency, the White House press secretary, Sean Spicer, refused to acknowledge the current unemployment rate and concluded "For too long it's been about stats, Mara. And it's been about what number are we looking at as opposed to 'what face are looking at?'"

This idea of refusing to acknowledge numbers and statistics bothers me. As someone whose life is now dedicated to medicine it troubles me. In medicine we use numbers and statistics. They tell us how best to approach a patient.

In medicine, at least here at UCSD, there is an emphasis on treating the patient and not the disease. We call it humanism in medicine. And while Spicer is trying to employ the same strategy, he fails to acknowledge that those numbers and statistics help us treat that person or family he talks about. He uses anecdotal evidence to support his cause, which is one of the must frustrating things to deal with in medicine.

Further the new administration has now banned some of its federally employed scientists from sharing knowledge learned and gained through tax-payer funds. In this new age of science denial, it pains me to see politicians use the idea that, if you can't beat scientists with science—then shut them up. Suppression of

knowledge sets humanity back—there is a reason we study the things we do, so the freedom of information is important in not just advancing medicine, but advancing humanity as well.

It would bother me if we took this same approach to treating our patients—if we were to use the face of one patient to treat another, instead of the science and statistics we've used as a basis of medicine. What if instead we used ginger to heal cancer instead of the vast array of new treatments we've discovered because it worked for my friend's grandma? What if we refused to treat meningitis in a newborn with antibiotics simply because there's been a case where one child survived it? What if we stopped giving our kids vaccines because someone got a vaccine and was later diagnosed with autism?

The sad truth is we are already starting to do some of these things. Science skeptics use anecdotal truths to skew their view of reality. They deny science in the name of that one friend that had a bad experience, instead of the numbers used to prove that the benefit outweighs the costs.

While government is edging closer and closer to the end of the spectrum of fascism, medicine too faces its own pains and difficulties in treating patients. Today more than ever, the government's influence has bleed into medicine, allowing politicians to dictate healthcare instead of scientists and doctors. It is only my hope that this influence will at least try to use science to help treat the people they are affecting. I worry that the government's next step may be simply to start burning books instead.

Appendix H:

The last many months have been a reality TV show for what we all know is the U.S. democratic process in action. A widely questioned and despised women about to break the grass ceiling vs a hot-headed no-filter man trying to break into the political arena at the highest office in this land without ever holding office previously.

Along with the presidential election comes a slough of propositions put on the ballot to allow the people to decide matters instead of the politicians they elect. In a presidential election year, higher turnout is expected, and several liberal propositions are more likely to pop up on the ballot. This year is by far no exception.

So I give my personal take on this year's ballot, with noted thoughts from the perspective of a medical student. Here goes nothing.

Office: President

Who I'm voting for: Hillary Clinton

Thoughts for: I'm with her. It comes pretty easily down to who is better fit to be president. As previously mentioned, Donald Trump is hot headed, with little to no political experience. He says literally whatever he wants. Hillary on the other hand has all the experience in the world. I think she does genuinely care. She's smart and well-thought out. Donald is not. The whole thing is quite a joke.

Thoughts against: She has a bad rap, but I don't think anyone can get out 30 years in the offices she has held unscathed. I think the only reason people are voting for Donald is because A) the don't like Hillary, or B) They are die-hard republicans and Donald could murder someone on live television and they'd still vote for him.

Medical perspective: Probably the biggest issue debates

TL;DR: Go Hillary! Boo Donald!

Minutes spent reviewing: The last year and a half (Hillary announced candidacy April 12, 2015)

US Senator: Kamala Harris

US Rep 53rd District: Susan Davis (incumbent)

State Senator 39th District: Toni Atkins

State assembly 78th district: Todd Gloria

San Diego School Officials: No vote

Proposition: 51

What it is: School Bonds (funding for K-12 and community colleges. $9 billion for construction and modernization of schools.

Thoughts for: School budgets have been slashed major since I was in middle school. I still remember my teacher fighting for that last ream of paper. Now's a good time to start rebuilding our schools. California schools do deserve more funding, and that comes from the perspective of someone who left the system that would benefit from this about 8 years ago. Say yes if you want more money to schools. I think the public school system is so important and is something often taken for granted.

Thoughts against: Legislature and governor oppose funding. $35 billion in construction bonds since 1998. Biggest reasons for no is that there are some questions in exorbitant cost ($9billion + $8 billion in interest), as well as accountability-- who controls the projects. Thoughts that it is too much money-- already paying tons in school bonds-- may convince one strapped for cash to vote no. Some call it reckless because there's already so much debt. Groups that aren't directly invested (like editorial boards) tend to lean no. Also-- the allocation is questionable because funds apparently don't go to the neediest school districts.

What I'm voting: I'm voting **NO**. Argument still stands that money may not go to schools that need it most. Needs more local control. Considered money grab by construction companies.

Medical perspective: Relationship to medicine is a reach… but…. As a medical student, who looks at those around me and where they came from, I realize that the lack of diversity in medicine isn't so much a medical school admissions committee issue, but moreso a pipeline issue. Students need all the opportunities they can get. Kids coming from communities with better schools, kids whose parents can afford a private education-- those are the ones who benefit from the current system. More funding for public schools can only make them better even if it's a marginal improvement. We need to invest more in our schools and give to schools that NEED it.

TL;DR: Vote yes for better public schools! Vote no for fiscal conservation and accountability!

Minutes spent reviewing: 11 min 43 sec

Proposition: 52

What it is: Medi-Cal Hospital Fee Program. It has already apparently been in action-- this prop just extends the program indefinitely. This continues the tax on private hospitals to provide funding for health services provided for low income people. Kinda like a Robinhood healthcare program-- but gives back to those hospitals for providing services to people with medical etc.

Thoughts for: Widely supported, virtually no big groups in opposition. Maintains status quo. Provides funding to programs that give access to low-income people on medi-cal, uninsured patients, children's health coverage. It's really only up for vote cuz California hospitals don't want legislators messing with the wording of the program already in place. I'd like to side with the California Hospitals. I hope they know what they are doing.

Thoughts against: Not much!

What I'm voting: YES to continue funding services like Medi-Cal!

Medical perspective: See all of the above.

TL;DR: Vote yes to continue a program that gives funds to hospitals that provide services to low-income groups. Vote no if you despise low-income people receiving health care.

Minutes spent reviewing: 10 min 55s

Proposition: 53

What it is: Revenue bonds >$2B would require statewide voter approval. A strange one being argued-- the official voter guide seems to use exaggeration to prove their point.

Thoughts for: Voters should have a say in large projects-- particularly expensive projects.

Thoughts against: Let's let the government do it's job and have elected officials make these big decisions! I don't have time to look over every $2B proposal, nor do I think the public will wisely research the proposals and vote appropriately.

What I'm voting: No. We all allowed voters to vote on high speed rail, and I'm not sure how that's worked out for us.

Medical perspective: Apparently no exemptions for emergencies like a natural disaster-- but it's argued that it likely wouldn't be a revenue anyway. The only reason I put this under medical perspective is because I suppose we should always be prepared for an emergency?

TL;DR: Yes for more voter oversight. Vote no to let the government do its job in deciding these things.

Minutes spent reviewing: 8min 54s

Proposition: 54

What it is: Online legislature. Requires pottential bills to be online for 72hrs prior to vote. Also would put proceedings onto the internet. Costs about $1M annually in addition to $1-2M starting cost.

Thoughts for: More information = more power! The public should be informed on whats going on…. But they probably won't take that time. But there should at least be avenues to accessing it! The 72 hours would give enough time for rabble-rousers who follow along to cause a viral stir. Ridiculous bills could gain some anti-momentum with our

online reddit and 4chan crowds. This does make politics a bit more interesting and certainly more engaging for a disillusioned millennial crowd. Also-- holding politicians accountable is always a nice thought. It's kinda just like expanding C-SPAN right?

Thoughts against: No one's gonna watch that crap. Also $1 million per year??! I could make a youtube channel for cheaper with my $400 cell-phone! Also-- 72 hours for a bill to pass! I like my bills to be enacted as fast as possible! No one's got time for that (a state of emergency can waive the delay by legislative ⅔ vote).

What I'm voting: Voting **YES** because I think 72 hours is reasonable-- especially because last minute changes should be matched with scrutiny. Only hesitant because the price tag seems excessive.

Medical perspective: Coming from a medical school who tries to podcast (With some serious issues!) I think an online presence is important. I do question the $1-2M costs associated with this. Does it really require that much money to upload something to youtube???

TL;DR: Yes for more political oversight with an online system and 72 hour wait period for bill ratification. No to maintain the status quo.

Minutes spent reviewing: 9min 30s.

Proposition: 55

What it is: Tax extension to fund education and healthcare affecting incomes >$263k.

Thoughts for: Tax is already in place since 2012 and will go to 2018. This will extend tax to 2030. We like extra money. Like previously said-- in the prop 51 argument, schools still need money. Also some of the money funds medi-cal.

Thoughts against: In 2012-- was a temporary tax to alleviate budget issues during the recession. Now we are out of recession, this tax should be removed. The economy is doing well, we don't need this bandaid anymore. We also shouldn't become dependent on this revenue stream as it's heavily influenced by how the economy is doing.

What I'm voting: A lland use tax would be more effective when income tax rely on volatile market that can be problematic when we later depend on revenue and economy tanks. However, I'm voting **YES**, because, again -- I'm not fiscally conservative. And more money for schools and healthcare is hard for me to say no to. Even if I were in the affected tax bracket-- I like seeing the money going in this direction.

Proposition: 60

What it is: Requires porn stars to use condoms, and requires producers to pay for healthcare associated with practice (vaccinations, testing, etc.)

Thoughts for: Good for public health.

Thoughts against: Both democrats and republicans are against. Will push people into filming underground/elsewhere (LA County has done this previously). This is a trial prop-- lawyers are going to feast on this.

What I'm voting: Yes. I spent a long time in undergrad teaching people sex-ed. People are stupid. Also the most important thing is to protect the workers.

Medical perspective: Yes for public health! Protects workers, and encourages use of condoms from a societal perspective

Proposition: 63

What it is: Restricts access to ammunition. Creates more checks during sale of ammunition. Requires permit for ammunition (there are hunter exemptions). Makes existing laws stricter.

Thoughts for: Makes it harder to get ammo. The NRA and republicans are against this prop.

Thoughts against: California already has passed many laws this year. Right now dealers already have to check with DOJ but do not need permit. Right now if you buy ammunition from out of state, you have to have it delivered to licensed vendor. Doesn't really change much.

What I'm voting: YES. I don't care about guns. Should reasonably reduce guns.

Medical perspective: Guns are bad for your health

Minutes spent reviewing: 5 min 48 seconds

Proposition: 57

What it is: Allows pathways for parole for people due to non-violent crime.

Thoughts for: Libertarians and Democrats are for. Inmates can earn credits for good behavior and educational credits that can lower their sentence.
What I'm voting: YES is very reasonable.

Proposition: 58

What it is: Gives local communities the ability to choose how to teach english to english learners. Previously debated how to teach ESL students. Law determined there would be no bilingual education. This would overturn this and allows schools to decide if they want something other than english only programs.

What I'm voting: Vote **YES**: we can give local control over how to let people learn.

Appendix I:

https://docs.google.com/document/d/1DJ-D-rzzZ8yrImvFYtD2s7C8y5DgWvvyR_uNvczbKsc/edit

Interview Reflections and Primers

Seattle Children's/University of Washington

To know before interview: Don't book an early after interview flight! Traffic can be stressful after. Also don't drink coffee before hand. There's coffee in the waiting room, plus coffee at morning conference, and there is a good chance 2-3 of your interviewers will take you to starbucks and offer you a coffee…. There's too much coffee and if you are one of those people who can't say no to an offer during an interview-- then definitely don't drink the morning coffee.

Interview day: About 10 total interviewees. Breakfast and Lunch are served-- no need to eat before hand. 3 interviews [1 resident, 2 faculty]. May need to go to harborview for interviews (they uber you). Interview day includes morning conference, noon conference, tour. Will go till about 4pm. Do not book flight before 7. Traffic can be stressful (although apparently only takes about 40 min to get there by uber according to program director).

Cool parts of program: WWAMI sounds like an awesome program (2 months in rural areas of Washington, Idaho, Montana). New building just opened with lots of open space and several resident team workrooms. Intern retreat sounds really cool. Huge program with 5 days to spend with other 41 interns. Although probably why there's only 3 weeks vacation. Huge catch area-- people come from all over WWAMI. Resident led night teaching (with breakfast sandwiches). Strong house staff union for all residents. The hospital is HUGEEE.

Bad parts of program: 3 weeks of vacation. Trauma's all go to harborview but you do get several rotations there as a peds consult including pediatric traumas. No epic.

Overall thoughts: I think I'm in love with this program! Residents all super nice. Elective rotations are cool. People seem pretty relaxed. A lot of resident support.

UCLA (Mattel Children's)

To know before interview: The parking kiosk is outside the parking structure, so don't turn into parking structure before getting to kiosk on Westwood Plaza (I totally struggled finding it even though it's circled directly on the map-- don't be stupid like me, and just go to that circle).

Interview day: Breakfast provided. About 13 interviewees. Morning session talks about program. Then you either do tour or interview, and then saw with interviewees and do whatever you didn't do. Then you have lunch at noon conference (pretty good lunch!). Afterwords you have a quick debrief and you are done by 1:30ish! Explore the campus if you haven't seen UCLA. It's RIGHT there!

Cool parts of program: Diversity of different types of hospitals (Academic vs community vs county vs private). You get lots of different exposure, and residents actually seem to like working at several different hospitals. Opportunity to do global health elective in 3rd year with preexisting partnerships. Cedars Sinai pumps out babies like no other so you get a lot of newborn and nicu there. Fantastic facilities (Mattel built in 2008). Right on campus. Food is fantastic. Good resident benefits. Offers campus couples housing-- and it's cheap! Some ED experience at CHLA! Good resident community "our class hangs out all the time!" People really did seem like they knew everyone.

Bad parts of program: Ronald Reagan (top 5 hospital in the country!) holds Mattel, and actually gets the more complex kids-- medical students don't really rotate there even though 40% of your time is spent there. No housing stipend, and area is kind of expensive. Residents are split across the 4+ hospitals, so there are long periods of time where you might not see your friends.

Overall thoughts: Pretty good program! I would be happy there. Residents are super nice (kinda like everywhere I guess). A little disappointed no stand-alone children's hospital-- but the pro's of variety/exposure are nice!

USC/LAC + USC Medical Center

To know before interview: They tell you to park in lot 9. It's divided into a b c d-- just go to 9d (only one with arm open). Also Traffic sucks pretty much wherever you are coming from, but you do have to get there early (7:15am).

Interview day: About 18 interviewees. Start with an introduction, then do some sord of didactic/problem rounds type thing. Afterwards, get introduced to Violence Intervention Program, which is a big part of USC given types of patients they see, a lot coming from abuse, trafficking etc. Then split and do tour vs interviews. 2 Interviews. Very chill. No one looked at my app before hand. Interviewed with program director Dr. Salazar. He likes people who set goals for themselves, so have at least something to say about your future.

Cool parts of program: It's all about the patients. Every resident says they chose USC because of the patient population-- the county hospital is LA's safety net. Virtually everyone they see is on medical or non english speaking. They really feel like they have

an impact. A lot of alumni stay at USC. Seems to have good mobility (can go from chief to faculty pretty fast). Lots of diversity of residents coming from many different places-- Lots of DOs. Some rotations at CHLA, but mostly at LAC. VIP program heavily emphasized. Excellent match rate for fellowship with great programs. 100% board pass rate last 3 years.

Bad parts of program: Residents were really cool. Applicant pool on interview day seemed a bit different. No stand alone children's hospital.

Overall thoughts: Pleasant program. Exceeded expectations. Not a shiny hospital but I can see myself being happy there. Traffic sucks.

UCI: CHOC and Miller Children's

To know before interview: Everything is pretty straight-forward. Good day—You'll be visiting both children's hospitals!

Interview day: Park in the garage that's in between clinics; parking will be validated. Arrival at 7:45am. There are about 10 interviewees on Fridays (more on other days). Start with morning report (they have breakfast!). Afterwards, you get a couple welcome presentations about the program, then tour through CHOC Children's. Next is a bus ride. You do ice breakers on the bus ride (about 20 minutes to get to Miller Children's). At Miller you do a noon conference, and about half of interviewees do their interview (half hour, 1 faculty). Lunch is served—it was really good! After noon conference you all do a tour of Miller Children's. It's pretty much

your standard children's hospital. Finally you shuttle back to CHOC, and the remaining people who have not interviewed do theirs at CHOC.

Cool parts of program: Everyone is so nice. Large program (30/class) so lots of variety. Seemed really cohesive—lots of residents at the social. Residents come from all over (lots from Midwest) so you get a wide range of diversity among peers. Morning conference was one of the best I've been to. Noon conference was pretty standard (we did board review). Getting to rotate at 2 different stand-alone children's hospital gives you a lot of variety. CHOC is a lot sponsored by Disney, so you get a lot of Disney Magic throughout the year. They do have a heavy tourist patient population. Also close to Disney which is cool! Program administration was fantastic—great PD and APDs. The little extra's they had for interviewees made it seem like everyone really cares about the program. The combined program (merger between Miller program, and CHOC/UCI) is pretty recent, but it seems like they've done a lot of great things moving forward. Pretty competitive to be a chief (9 people applied this year)—good sign meaning people like the program!

Bad parts of program: Two hospitals means that no matter what you'll be commuting some of the time. Interns here seem more overworked than at other places. Pretty much all interns have a "I knew it was going to be hard but I didn't realize this hard" mentality. Interns at morning conference also didn't seem as knowledgeable as other places.

Overall thoughts: Would definitely be happy here. Residents are super nice and I see myself fitting in. Don't know how I feel about being in Orange County/Long Beach.

<u>Boston Combined Residency Program</u>

To know before interview: UHAT is a subcategorical program, but it's essentially the same as the categorical program, with a little bit of an emphasis on primary care in the urban setting (you do a couple more rotations at the community hospital). Apply to both! It's essentially the same training otherwise. The combined aspect of the program is a lot more separate than I realized. Different program directors, different faculty, different chiefs at the two sites. You may start at either of the 2 hospitals, so don't bank on being at a particular one (either way they are pretty close so transport isn't terrible if you are near the wrong one). It's a super long day so try to get some good sleep.

Interview day: One of the earliest starts (7:15am), and latest ends (4:45pm, with social right after). The entire group (about 30) is split into 2 and you start at opposite hospitals and switch in the afternoon. You only interact with the other half at the social. In my instance, I started at BMC, and ended at Boston Children's Hospital. Started with a morning report/lecture. We had a few informational sessions (they like ice breaker questions). Half do tour, half interview, and then you switch (1 faculty at BMC). After the tours/interviews, they shuttle you over to the other hospital. You have lunch with faculty and residents, do more informational sessions, then do the tour/interview again (1 faculty at Children's). At the end, they either walk or shuttle you to a happy hour, where the residents go HAM.

Cool parts of program: Residents seem to love the program. Good balance of intense interesting medicine at Children's plus bread and butter of a community hospital at BMC. Lots of medical students given you are associated with two medical schools. Large diversity in residents given the two types of programs (categorical vs UHAT). Also strong

emphasis on diversity with the Diversity Council. Lots of supportive faculty. Does not seem like an "east coast program". Residents seem to know each other well. Social was very social with a huge turnout (although they are a huge program). Lots of residents with partners. People seem happy. No central location of residents, but a lot of people like Brookline. Can get a central location but means it's a good 20 minute walk from both centers. No payback for jeopardy call. Benefits are decent. (Better than UW, not as good as Stanford).

Bad parts of program: Winters are cold. Fairly competitive. Harder to become a chief as usually there's a lot of desire to be a chief. Two hospitals, so commute is guaranteed. xz

Overall thoughts: Loved it!!! In par with UW program.

UChicago

To know before interview: Nothing really! Multiple trains go there-- just plan your arrival accordingly!

Interview day: Arrive in the lobby at 7:45am, and you'll be guided to where you need to be. There are about 10 of you. You'll attend a morning conference and noon conference, both with food. You get 1 resident interviewer, and 1 faculty interviewer. Both very "chill". The day ends around 2pm with a debriefing. No powerpoints today! Program directors just like to talk off the cuff.

Cool parts of program: Everyone seems very happy with where they are. Teams are quite large, so you are often working with colleagues (Maroon team [general

hospital] has 2 seniors that work together. This program reminds me of UCI in terms of resident feel. Class seems very cohesive and everyone gets along well. Living is fairly affordable compared to most other cities (can get a nice apartment in heart of downtown for 1k/month). Hyde park provides an interesting low-socioeconomic patient population. Hospital is in the middle of UChicago which is beautiful. Program director is super friendly and super cool—a very easy person to talk to. Program is resident driven and faculty are very receptive to resident opinion.

Bad parts of program: Distance can be quite a commute if you are coming from Chicago (15 minutes express train plus 25 min walk, vs 45 minutes on bus). Hospital itself doesn't seem as homey. Also feels less busy. Teams can be very large.

Overall thoughts: I could see myself at this program, but it does lack some magic.

NYU

To know before interview: If you can find someone with on campus housing—the commute is <2 minutes. You can pretty much live AT the hospital!

Interview day: You meet at 7:45am in the Tisch lobby. There were 15 interviewees. You start morning with breakfast at a morning conference type presentation (jet lag really gets you here!). You then walk over to the Bellevue Hospital where most of your day is spent. You get a presentation from the program directors and then start your interviews (2 faculty). Afterwards you get a tour of the Bellevue Hospital, followed by lunch with residents. Lastly, you walk over together back to Tisch Hospital for a tour before dispersing.

Cool parts of program: You get two hospital settings, one very much underserved, and the other not. Shows the dichotomy of two very different worlds. People love the patients at Bellevue (very gracious, grateful). New hospital tower is in progress with a dedicated pediatric portion (essentially a standalone). Will have private patient rooms. Salary is approximately 63k in the first year, which should do a decent dent in the cost of living. Campus housing is also fantastic, (~$1700) and they prioritize out of New York residents. Probably the best location of the hospitals in New York.

Bad parts of program: A lot of time is spent at Bellevue hospital, where amenities aren't great. Has the feeling of an old run down hospital. Call rooms are dingy.

Overall thoughts: Reminded me a lot of UCLA. I think it being in NY would put it over UCLA. I could see myself happy here, although everything seems weirdly "dark". I don't know what that means.

UC Davis

To know before interview: Park in the parking garage, and press the button for a parking ticket even if arm is already open (although if you forget it's fine too).

Interview day: Pretty early day. Morning starts at 7:15ish with a morning report type thing. They have breakfast (not exactly the best…). They also give you really leaky water bottles to carry around. There's about 15 applicants. They do 3 interviews (2 faculty, 1 resident). They try to match you with a resident from your school, so good chance you may see Erin Platter (Peds Class of 2018). The interviews are kind of structured in that it seemed like there were specific questions they wanted to ask (a challenging time, ethical dilemma, etc.). People seemed to like Davis for its location. Affordable area, people are

able to purchase homes, good for families, etc. Residents often compared it to CHO ("I was deciding between UC Davis and CHO"). Chiefs seem really cool, but there are only 2 of them, and they guide most of your interview day. Tour is long, (like an hour 15 minutes). Hospital is nice, but it's not stand alone, and you see a lot of it. They walk you over to their administrative building for interviews.

Cool parts of program: Smaller program means a lot of attention, and you generally know everyone and all that is going on. Sacramento is a "hip up and coming area" that is getting Bay area overflow, with a still reasonable (so far!) cost. Per Erin Platter, the faculty are much younger and super receptive to new ideas.

Bad parts of program: Smaller program means, if someone's sick, all hell breaks loose (kidding). But Jeopardy-system requires pay back (unlike Boston). Morning report-- residents didn't seem at similar level of engagement as at other places.

Overall thoughts: Could see myself here, with lots of room for career advancement. They really like their own people! Also support of home is kind of nice. Small hospital without standalone children's which feels especially so.

Stanford

To know before interview: They don't say it on their emails-- but parking is validated! Don't walk super far like I did! Also housing/hotels are expensive, so find friends to host early! Or consider AirBNB. Could also recommend a car because there's lots to see in bay area, and you can get a cheaper hotel further away.

Interview day: Starts at 7:45am. Begin with a morning report led by a chief. Afterwards, you get a presentation by PD and Chief about the program. After that everyone breaks

off into interviews. You return for a noon conference (good food!). After noon conference, you go through a tour of the hospital, and end at the (small) resident work room where you talk to some of the house staff, and ask your last questions. Social usually later that night. ***Note*** You have 3 faculty interviews, and they are structured much more so than any other interview. They have a list of about 3 questions each that they ask you (with a section on the bottom for scoring). The questions range from "tell me about an adventure" to "Tell me about a time you have had to provide conflict resolution" to "tell me about a frustrating experience" to "here are 5 pages, triage them". This isn't as bad as it sounds as it's pretty conversational and every interviewer has the attitude of "I just have to get these questions out of the way first." They also ask you what you would like them to emphasize in your application while they are in committee.

Cool parts of program: The benefits are fantastic. Essentially extra 10k/year in stipends so your total income is about 73k-- which is a good amount to cover the extraordinary cost of living in Palo Alto (did the math, it comes out to about 900/month more compared to a no-income-tax place like UW with 53k salary). Also another "top tier" program in terms of name, resident resources, children's hospital. Location is pretty awesome despite cost of living. Beach, mountains, city, snow in all directions. You have all the resources of a world-class institution at your fingertips (they give you access to on campus amenities) -- I'm also biased in that I went to Stanford for undergrad.

Bad parts of program: Cost of living is really intimidating. Even booking a hotel is painful, letting alone paying rent. Definitely a driveable place, that has better traffic than LA, but worse than most places. Hospitals are pretty far, so you'll have some commuting no matter what. Sounds like 2nd years have lots of lonely "only resident" rotations. But I guess that's at lots of places, they just mentioned it more during the social here. Chief

residents split up work so they don't seem as cohesive/team-like as most other programs (1 chief always at santa clara, 1 at stanford, 1 wherever)

Overall thoughts: I could see myself very happy here. Lacks the magical enthusiasm as places like UW and Boston. Very chill though and residents seem well cared for and happy.

Yale

To know before interview:

The hotels can be discounted to up to 99$ for residency interviews. Omni's super nice and right across from where they did the social (Prime 16). Their Ice Breaker is their program director asking you questions about ONE THING THEY WERE CURIOUS ABOUT IN YOUR APPLICATION. Totally threw me off guard—was a very small thing I had very little to say. She says it doesn't reflect anything about your app. Also, Dr. Haddad used to work here and there's a little plaque that shows he won a faculty teaching award in 1990-1991 there in the resident work room—my interviewer said "So you know Gaby!" and I at first had know idea who he was talking about. Breakfast is provided.

Interview day: We met in the lobby of the cancer center (there are 2 cancer center buildings so make sure to go to the right one). They took us to a conference room where we got breakfast and got to know about the programs. The interviewers only asked me 2 questions, "Why are you considering Yale?" and "Do you have any questions for me?" Afterwards you get a tour followed by lunch. After lunch, there's a debrief session and you finish up there PD's questions about each person's application.

Cool parts of program: Lots of resident support with 26 residents/class. New Haven has a lot of diversity, and it's pretty much the place to go to in New Haven. Residents match really well and seem to go wherever they want. Program provides everyone with a phone. They use Epic! The area has a small college town feel. Big food and music area so a decent amount to do. There are lots of different good places to live.

Bad parts of program: Teams are quite large so you don't get as much autonomy, however there's plenty of autonomy over patients. There are 3-4 seniors on a team, and 3-4 interns on the team. They do not provide daily lunch or breakfast, but do give

Overall thoughts: Was a nice program, and residents seem to have a relatively easy time going through it. I could be happy there, but there seems to be a little bit of Oomph missing from this program. Felt most similar to UChicago's program.

Columbia

To know before interview:

The medical center is far from everything else NYC. It's in Washington Heights around 168th street and Broadway. Prepare for a trek if you aren't going to be staying nearby (Can be a 1.5 hr commute if you are coming from Brooklyn)! It is near the MPH school so if you have any friends there—hit them up! NYC is really expensive so hotels are hard to budget for. They have good bagels for breakfast!

Interview day: Arrive in lobby to go through security—they will lead you to conference room. You have an intro to the program followed by a morning report.

After morning report you have a tour of the hospital followed by two interviews. The interviews are rather chill (they asked me more about specific items in my application than most programs—one in particular wanted to ask a lot about research).

Cool parts of program: Seems to be New York's premier children's hospital, and until NYU builds it's new center, is pretty much the only stand alone in NYC. It's a sizeable 26 residents/year program for a ~200 bed hospital. Is a very competent program—the residents seem very intelligent. There's definitely a New York feel to the program and their confidence, but still a very kind and pediatric program. The program director, Steve Paik, seems really cool and approachable. Residents speak very highly of him. Food catered 4 days a week.

Bad parts of program: They do not use Epic. It's far from everything NYC. No food Fridays. The hospital has gone through so many name changes. There are only two chief residents.

Overall thoughts: Seems like a great program to go to if you want to be in New York. Would be really happy hear so long as I can survive that New York City life.

Cincinnati

To know before interview: They reserve a hotel for you and feed you double breakfast (hotel and hospital). They are receptive to sending an "interest" email.

Interview day: You get shuttled early in the morning. People worry about doing the buffet breakfast that starts at 6:30 and making the 6:50 shuttle, but it's totally doable

(and recommended because the breakfast was pretty bomb). They usually interview 8-9 people/day. When you get there they do a quick introduction to the program, and then you head to morning report. After morning report you have a lot of time with the Director (whose ice breaker is to ask about your personal statements), followed by an hour with one of the PDs to ask questions. After that, everyone has some combination of half hour breaks, half hour interviews, hour tour, with lunch thrown in there. There are 3 interviews (PD/APD, Faculty, Chief resident). They are pretty good about having lots of questions, but it's a pretty relaxed interview. Expect the "any ties to the area?" question.

Cool parts of program: Huge catchment area, and get's good mix of community bread and butter + tertiary specialty care + quaternary care. People are all SOOOO nice—applicants included. Surprisingly diversity in where people come from, not an excessive amount of Ohio place. There's a surprising amount of IMG and DO students at this program. The hospital is absolutely beautiful with SO MUCH SPACE! They cater lunch AND breakfast every day. Food was pretty good at my interview! There are five chief residents. Chief year is described as "hardest thing you will ever do." They use epic and are trying to get rid of pagers!

Bad parts of program: Only 1 guaranteed day off for holidays and you only get one of Thanksgiving, NY, or Xmas. Program is a little less diverse than other programs (Midwest, very white female). Difficult to fly to—it's troubling when there's great excitement among the program that "Southwest is coming to Cincinnati next year!" There's not as much to do as in a bigger city.

Overall thoughts: People seem very happy here and I can see myself being very happy as well. Rent is cheap. Lots of people talk about staying and how it's easier to settle and start a family there.

Denver

To know before interview: The hospital is in Aurora which can be difficult to get to by public transit in Denver. It gets really cold even in November so pack appropriately!

Interview day: You begin the day with a morning report with breakfast. You then get an informational session about the program followed by a tour. After the tour you have two interviews and then are brought back to the conference room for a lunch with residents. After lunch they take you to get gelato and coffee before they send you on a shuttle to Denver Health to get a tour and a final panel.

Cool parts of program: Dedicated education days once a month and occasional noon teaching-- there is no daily noon conference. You still get lunch and breakfast every day though! The hospital is relatively new, very spacious, and absolutely beautiful. You can see the rockies from some windows! Everyone seems really competent. You get a balance of community medicine at Denver Health

Bad parts of program: The Denver Health hospital is about 45 minutes away. Diversity seems to struggle a bit although they do have an "award winning" diversity committee. Anschutz (person hospital is named after) is apparently a very homophobic family, although they are assured their influence in hospital politics is minimal.

Overall thoughts: I really loved this program. Everyone seems so happy and Denver is a beautiful city.

Miami Children's

To know before interview: They book you a hotel room and breakfast is provided at the hotel with some snacks at the interview as well. This was probably the worst logistical interview I've ever had (stuck in a room for 3-4 hours waiting for everyone to do 20 minute interviews).

Interview day: Miserable day. I do not recommend the red eye! Although I was able to check into my room at 6am which was nice to settle in before my interview. You do not attend any morning report or noon conference. You get a tour of the hospital which is beautiful during your 3ish hour session with the chiefs with periodic interviews interspersed. Their idea of a social is taking everyone out to a nice lunch (Seasons 52). Only 3 residents to interact with at lunch. Their program presentation is **at the end of the interview day**. They shuttle you back to the hotel right after the interview day ends around 3:30.

Cool parts of program: Really nice hospital, really big program.

Bad parts of program: I wonder about the feel of the program given that the chiefs and program directors don't really have a sense of how miserable their day is for applicants. Everyone in the shuttle on the way back to the hotel complained about how it was one of the worst interview days. Their teams are huge-- 6 medical students, 3-4 seniors, 3-4 interns on ONE team!

Overall thoughts: I really did not like this program. The hospital was very shiny but the program itself has a lot to work on.

Appendix J:

In 2006, as part of my high school marching band, I joined dozens of Northern California Marching Bands to perform at Cal Band Day—a day of events lead by the Cal Marching Band, that climaxed in a half-time performance in their game against Arizona. This day soon reassured me that my marching band days were numbered, and that a college marching band was not for me.

In 2007, I performed for the last time in my high school marching band. That last day was full of nostalgia as I remembered the long days, the longer weekends, and the many friends I made in band.

I received and email that December notifying me of my acceptance to Stanford. In it was a link to a website that played the band's defacto fight song, All Right Now. That song has since been associated with happy memories. Little did I know that despite my determination to not continue band in college, I would soon learn to play that song myself.

Later that next week, I excitedly told my honors biology teacher (a Stanford alumna, and my letter writer) the good news. Her first response to me, "You have to join the band." She sat me down at her computer and showed me the band's website—a tribute to irreverence. It was a wacky welcome into the world known as Stanford. She laughed recalling memories of watching the band and how cooky they were.

In April 2008 I attended Admit Weekend. I remember attending the University welcome at Memorial Auditorium. I awoke towards the end with new friends giggling at me as I had apparently drooled all over myself. That was a good nap, I told myself. As I exited the auditorium, my ears perked up to a raucous sound. The LSJUMB perking up my senses. And then I saw them: a flame coming out of one man's hat, half nude individuals jumping in the fountain. An energy suddenly filled the crowd. I stared at them and whispered to my friends with a sudden realization: I'm going to be one of them one day. The band started playing a song I would later learn to be "White Punks on Dope" and slowly charged the crowd. An alto sax passed me, who I would later know to be the sexion (band lingo) leader. I hugged her wanting to tell her I was going to be with them one day.

My first night at Stanford was chaotic. The Stanford Band gave Freshmen the unique opportunity of having it's first "All Campus." It's many students' first opportunity to learn when to jump during All Right Now. These memories are what lasted a life time and what I hold dear.

Throughout college, band was always my constant. The way the band set me up for success is something I will always owe to them. They sparked an important part of my personality that I'll never forget.

RIP LSJUMB 1963-2016

Appendix K:

Dear Provost Etchemendy,

I write to you as an alumnus of Stanford and former member of the LSJUMB. I suspect you are hearing from a lot of us, and would like to share with you my personal perspective on the band.

First I would like to share with you why a **Student-Run Band**, in particular the LSJUMB, is important to me. I came to Stanford an overeager Freshman having already spent four years in a tiring work-hard, play less marching band in high school. While I much cherish those times, I was ready for change, and did not originally plan on participating in band in college. That quickly changed when I learned what the Stanford band was about—personal expression, community, and a mental outlet for people like me.

I joined the LSJUMB as soon as I could. And I quickly learned it was the one place on campus I could thrive. My Freshman year was marked by challenges. Even as an extrovert, I found it hard to find my people. I heavily involved myself in the LGBT community, the Asian American Community, and soon found myself isolated in both of these communities—the reason being that these communities lacked an intersectionality I needed (something I worked hard in my four years to change!). I was a part of an API community that considered me whitewashed, and an LGBT community that didn't understand why I was not out at such a free and welcoming place as Stanford.

I found my home at the Shak. The Stanford Band quickly became my family. People from all walks of life at Stanford joined the band, and it was my one opportunity to meet people from just about every background. As I watched my API friends fence themselves off in their Asian-American sub-communities, and my LGBT friends dive further into Terra Happy Hours, it was at the Shak that I saw the intersectionality I craved. And it was because the organization presented itself as a "come-as you are, make it what you want" community. It was to my surprise to see the band later castigated for being an unwelcome community, when I found it to be everywhere else that was unwelcoming. I can't understand why these accusations are put on the band when you could make harder accusations on my freshman dorm, my community centers, and just about every other student group I have had the privilege of knowing.

The student-run nature of the band is what kept me involved. It gave me a stake in my community's well-being. It provided me with responsibility, and allowed me to actively partake in the group's functioning. I never felt so part of a team while at Stanford than when I was with the LSJUMB. And the fascinating part for me was watching my fellow students take on these responsibilities and engage with their community because it was this home that mattered so much to them. To strip them of this very important status is removing the very core of its being. I can't imagine

my Stanford experience without the LSJUMB, and I feel you are depriving future students of a wonderful opportunity.

Even 4 years out, I find myself talking about how my LSJUMB experience allowed me to grow. In residency interviews for pediatrics (yes another soon to be doctor that was in Band), I continue to talk about how my experience in LSJUMB was my first experience in true diversity (of experience, of thought, of background, and of identity). It was where I learned how to be comfortable with being uncomfortable. The people of band taught me how to teach and to be heard. They taught me how to take things seriously without taking things too seriously. They gave me a balance of hard work and stress-relief. All of these things I owe to the LSJUMB and is why I've taken the time out of my busy schedule to fight for it.

It seems apparent from whispers and rumors, collected with recent press releases, and letter to the band, that there is an unacknowledged gap between University administration and Stanford's students. Instead of helping this much loved student-run organization to grow and change, it seems like the University has had its own agenda, creating an impossible atmosphere for current **full-time** students to succeed. Strangely the recent letter to the band has had the unintended effect of putting not the band in a bad light, but the university itself as it now seems shallow, manipulative, and underhanded. I've watched my friends and former mentees bend over backwards to achieve the ever-changing "goals" administration has placed on them.

There seems to be a lack of common sense in the administration in handling these issues (announcing right before finals?). Why hasn't there been more administrative support in preventing these accusations? Instead of being secretive about the "investigation", why not invest time in working with the students in achieving a shared goal? Where is the student engagement? Why have students been expressing discontent with administrative communication? Why all the secrets? Why isn't the administration doing its part to prevent this fall-out? Why have they determined that "nothing more will be accomplished without extreme consequence," when it's apparent to everyone how much the band has undeniably progressed in the last many years. Sure the band has required cultural change, and from this alumnus's view, they were on the appropriate track. This statement denies the hard work current leadership has put into playing by the rules. The only reason I can imagine this is happening is that it has wanted this all along and someone has had a step-wise plan to dismantle the LSJUMB we all love.

While I can't defend all of the band's actions, I would like to point out that in my experience I never felt pressured to drink in the band, or to partake in drugs which seems to be a central cause of recent punishments. If anything, there are other organizations more deserving of oversight and over-kill investigations. The band represented a cross-section of campus and was one of few organizations that truly reflected virtually every corner of campus life including people who disavowed alcohol. I do feel like the university is wrongly targeting the band in this bizarre

witch-hunt. Surely you will find similar transgressions if you spent as much time investigating Roble Hall.

I've slowly watched the university peel student privileges one-by-one from student groups since my time at Stanford (from Suites, to AKPsi, to XOX, and now the band). The university is almost unrecognizable to me as I once bragged about the student support, and ability for students to have control of their education and how their community would grow. Even at my recent residency interview at Stanford, did faculty brag about how the University is so open to ideas, and allowing creativity in the heart of the Silicon Valley. It seems like this is becoming less and less so every day. Since when did student-life become a last priority for the University?

I hope you did take the time to read my personal thoughts on the recent news and do hope you work in overturning the out-of-touch punishment that current members of the band face for a culture that is far behind them. Your time and consideration is greatly appreciated.

With funk,
Bradford Nguyen
Stanford Class of 2012

Appendix L:

With the results of the election now behind us, I'm now focused on the future and how to move forward. I've spent this last week mourning over the election results and trying desperately to understand what it means for me, my friends, and everyone I care about. I've read through countless articles that explain why we have this very unexpected turnout. I've reviewed numerous perspectives on the election. Some have been very impassioned stories, others provide me with a balance of logic and statistics. What I think I'm looking for is comfort.

For me, this election means a lot of things. Many things that have already been said that cover my greatest fears: how my patients will cope with the possible repeal of Obamacare, how my Muslim friends will battle continued racism and fear-mongering that leads to violence against their people, how the undocumented immigrants I care about now face increased scrutiny and deepened fear of deportation.

For me I am also selfish, and have worries that pale in comparison to those listed above. I worry about what I may have to deal with in the near future. I worry about the frustrations I will experience. In my immediate future, I worry about going to my boyfriend's home in Kentucky for Christmas.

I am a gay, Vietnamese-American man who has been with his white (also gay) boyfriend for two years. This will be my first time in Kentucky. And while previously my fears were "will they like me? Will they approve of me?", my fears are very similarly "Will they not like me because we're gay? Will they disapprove of me not only because I am a man, but I'm also not white? Are they going to write me off because I'm a California liberal, and we just had one of the most emotionally charged elections in recent memory?"

Kentucky is a red state. They were one of the first states called for Trump. And while the last thing I should do is be prejudiced about Kentuckians, there is a good chance that when I arrive in December, I'll have to defend my ways. Since election night, I've imagined the 1000 different things a person could say to me that may set me off. I have the unfortunate privilege of having to balance a (hopefully) good first impression, while also defending my values. I do hope that the things I talk about here are just things I'm imagining—maybe my trip to the South will be nothing but great.

I've decided I will use a few strategies on this 10 day trip. First I will have my boyfriend at my side for the most part. I will instruct him to put his hand on my shoulder whenever he thinks I may explode. It'll be a signal to remind me that I have his support, but also that I should think very carefully about what I am going to say. Second, I will try to avoid pure statistics and logic, because as we know—the hard

core Trump supporters have likely heard it all, and will not be swayed by facts. Instead I will try to focus on reasons why I feel the way I feel. I will try to start my responses with "I feel this way because…." And hopefully that can give them some insight into a liberal mind. Lastly, my goal will not to be to convince them of the things I believe in, but to find some common ground. I've been doing my best (and struggling) to understand this other side, and the best I can hope is that they will at least try to understand where I am coming from.

I do not know how this strategy will work, but I'll let you know in a couple of months.

Appendix M:

Reflections on the Match

It's been about 5 days since Match. Now that the dust has settled, I've had some time to reflect on the weird weekend that medical students across the country experience.

First, now that all is said and done, my personal opinion of Match is that it's terrible. It's an uncomfortable experience for so many people. Anticipation leading up to this day adds to its horror. It takes a little less than a month after submitting our match lists for the results to arrive in our hands. The month prior is filled with conscious ignorance of our inevitable fates. We dream about the many possible scenarios. We fill ourselves with anxieties imagining what our 1st through 10th choices will bring us.

Add this to the fact that the National Residency Matching Program themselves don't really make it easy for the rest of us. First, they show no flexibility to people or programs who for some reason are unable to submit their rank lists on time. An easy fix? Once the deadline hits, email everyone who has not submitted a rank list and give them a day to fix whatever issue they may have. They also have a terrible system that **uncertifies** your rank list if you decide to move rankings around. An easy fix? Just keep the last certified list as what they will use. If someone wants to uncertify their rank list, make a different button! But NRMP wants to make a game that adds drama. For these same reasons, they hold our matches for a month despite the fact that a computer program can quickly process the entire match. They give people who don't match a week to "scramble". At least they changed the name to something less gimmicky. Anyway—this is an aside to my personal feelings about the how the match unfolds.

I'll admit, I dreamed often of the match. Some people might even call my dreams nightmares. I would arrive at Match Day to realize I forgot to ever submit my rank list. I would open my envelope and find that I matched to my 2nd program, or my 5th program, or my last program. No matter the match, in my dream I was filled with anxiety and concern. It's strange realizing after match that those anxieties would exist no matter what showed up on that Match Day letter.

When the reality sets in that you are moving to a new place, about to start this next big journey, you unavoidably have 1000 new things to think of. All the different dreams and anxieties you had previously about the many different courses your life could take, are suddenly reduced to one new course—one new anxiety ridden, problem laced, still strangely uncertain course that you now have ~2 months to figure out.

After you open your letter, you have a split second to process what you are reading before you have to react in front of cameras, your family, and friends. I got my 3rd

ranking, and I'll admit I was a bit surprised. That split second of processing lasted forever. I realized in my head that I had to react. But according to my friend, my face said it all. She described it as shock. I'd call it "subdued terror". Now this isn't because I'm upset with my match. In fact quite the opposite—I'm relieved, and I'm happy.

The split second you have to react may be filled with a thousand different emotions, many of which are conflicting. At that time I felt confused—uncertain that I read my letter correctly. I felt relieved—I'd be closer to home and not on the east coast. I'd have a support system to help me through these next many years. My move will be easier. I spent four years in undergrad there, so the place was very familiar. The prodigal son shall return!

But at that same time, my dreams of living in a city disappeared. The relief of not having to live through a harsh east coast winter, was combatting the loss of adventure I was now feeling. I'd previously dreamed of leaving the beautiful state of California. This was one of my last chances to have a very defined stint at another location. My dreams of creating new roots in a new location, and making a new community of friends was combatting my new found excitement of renewing old friendships.

It's taken me a while to process my feelings. And it seems many of my classmates are likewise doing the same. The one consolation in the match that all of my matched friends share is that we did in fact match and don't have to wait another agonizing year to practice what we want to practice like some of our friends.

So—in the spirit of celebrating—hooray! But still, boo you Match.