Young alumnae in medicine inspired by social service experiences.
No one applies to medical school expecting it to be easy. But six young alumnae spoke with the Bulletin recently, and it’s clear that their formal educations in medicine have started during a particularly rocky time for the healing profession.

Many of these alumnae have taken out staggering amounts of loans to enter medical school, with no plans to specialize in one of the traditionally lucrative branches of medicine like neurology, with its starting salary of around $200,000 a year, or cardiology, which can start at over $350,000. Some want to combat the country’s shortage of physicians and pediatricians by entering primary care, but the numbers are daunting. “It does give me anxiety,” says Melissa Leedle ’05, a second-year student at Jefferson Medical College in Philadelphia. “I’m taking out a lot of loans to be in med school, and I don’t know how that’s going to affect my career.”

According to a survey by the Medical Group Management Association, the lowest starting salary in 2008 was for pediatricians—$132,500. Family practice, geriatrics, and urgent care also ranked low on the list. And on top of lower starting salaries, family medicine often means unpredictable working hours. Medical school students can have college and medical school loans topping $300,000, and some hope to start a family one day. In the face of these facts, America’s shortage of primary care physicians is hardly mystifying.

Meanwhile, regardless of specialty, no one in medical school right now knows what kinds of salaries to expect by the time graduation rolls around.

Fortunately, what sets this group of future doctors apart is the non-traditional path they all took to medical school. One thing is clear—they all knew what they were getting into. Each of these alumnae elected to take a “gap year,” or even years, before entering med school. They spent that time exploring career options, trying everything from high finance on Wall Street to volunteering in emergency care along the Israeli-Lebanon border.

According to Mary Beth Davis, a pre-med advisor at Bryn Mawr, this was almost unheard of among pre-med students just a generation ago. “Parents are often surprised and concerned by the idea of a gap year when they first hear it. In our generation taking a gap year before medical school was not common at all, and the parents are concerned that their daughters will not go back to school if they take the time off.”

Which is sort of the point, says Leedle. She spent her gap years in South Africa working for the Peace Corps. “I wanted to take this time to make sure that medicine is absolutely, one hundred percent, what I want to do. If I went straight through, there would always have been that lingering doubt in my mind. Could I have done something else? Now, I can say for sure this is where I want to be. In the long run, a gap year could make you a better doctor.”

Young alumnae in elder care
The gap years of Evie Kalmar ’07 took her around the globe, leaving a remarkable record of service at every stop. Since graduating from Bryn Mawr with a degree in chemistry, Kalmar taught English in Taiwan as a Fulbright scholar, volunteered at the side of the Union Carbide plant disaster in Bhopal, and served as an EMT along the Israel-Lebanon border. This fall, Kalmar began medical school at a relatively new and prestigious program in medicine and public health. It’s a joint program of two University of California schools—Berkeley and San Francisco—and anyone who graduated from medical school 20 years ago would likely find the curriculum shocking.

For one thing, her program is very small, without the 100 plus person lectures that form the bedrock of most medical school experiences. “There are no classes in the traditional sense,” says Kalmar. “The core of the program is Problem Based Learning, which means that all of our learning comes from actual cases, not textbooks. We start examining the case from the moment the patient walks into the office. Along the way, unfamiliar terms are going to come up. Like, if the patient’s chart shows their EKG is normal, someone in the class isn’t going to know what an EKG is. They raise their hand, and we all figure it out together.”

“It was a program that I found out about sophomore year,” says Kalmar, “and it sounded like the closest thing to a Bryn Mawr-esque medical school that you could find.” She admits

“I wanted to take this time to make sure that medicine is absolutely, one hundred percent, what I want to do.” — Melissa Leedle ’05
Evie Kalmar ’07 believes that the widespread problem of depression among the elder population in nursing homes is also an American problem—she’s seen the alternative in Beijing. “I was blown away by the vitality of the elder generation there.”

Kalmar hopes to specialize in geriatric care—her father is the medical director of a nursing home in San Diego, and growing up she would volunteer spending time with the seniors. “I would always go to work with my dad and talk to the residents, and I felt this underlying sense of depression there. It was clearly a very lonely experience for a lot of them,” she says.

Kalmar believes that the widespread problem of depression among the elder population in nursing homes is also an American problem. She saw an alternative firsthand, while studying abroad in Beijing in an intensive language program. “I was blown away by the vitality of the elder generation there,” she says. “One day I visited the Temple of Heaven in Beijing, and the park was filled to the brim with senior citizens. They were playing mahjongg, Chinese checkers, flying kites, walking around the park together. I was really moved by that sight—seeing elders outside of a nursing home, moving, laughing, and enjoying life.”

That experience settled it for Kalmar, she says. “Geriatrics is going to be a huge field—as the baby boomer generation ages, the number of patients is going to shoot up. I’d like to work in research and policy, but I know that I always want to develop relationships with the patients themselves. We have so much to learn from the elder population.”

Kirsten Poehling-Monaghan ’01 couldn’t agree more. She started her fourth year at George Washington University’s School of Medicine in July, and would like to specialize in orthopaedic surgery with a focus on geriatrics. A mathematics major and theater minor, she did statistical analyses during the summers and academic year for a medical research group at the Veterans Administration Hospital in Minneapolis. The experience sparked her interest in medicine. After graduation she returned to Minnesota where she worked in clinical research and hospital administration positions while completing the premedical science courses through night school.

While working at VAH, she noticed a link between elder care, depression, and bone health. “I was analyzing correlations between depression and osteoarthritis, which basically is wear and tear on the knees and other joints,” she says. “At the most basic level, the data was showing that people with osteoarthritis also tended to suffer from depression. It all sort of flowed from there. There’s a lot of really cool research in this field—the osteology of aging bone is fascinating.”

Poehling-Monaghan also felt personally drawn to the elder population. “I was an only grandchild, and I spent a lot of time with my grandparents. I was almost like a primary caretaker. I’ve seen a lot of the abuse that elders can suffer in the nursing home system.”

Poehling-Monaghan says there is an unofficial term in elder care for the neediest of these patients: GOMER. “ ‘Get Out of My ER.’ It’s directed at the ‘little old lady’ with several hip fractures. Or the old man who is confused because he’s on too many meds. Basically, old people with lots of problems that busy young doctors don’t want to deal with. But these people have lived such amazing lives, and have contributed so much.”

Like Kalmar, Poehling-Monaghan sees huge growth ahead in her field. “The coming set of baby boomers developed a whole new set of social norms that previous generations didn’t have. Many more women are childless, and divorce was less stigmatized for them. So it’s a big group, but also a group where many people don’t have a lot of family around.”

Poehling-Monaghan also sees change ahead for women in her field on the other side of the operating table. “Orthopaedics is a really male-dominated field; she says. “It has an abysmal rate of female residents, in part because
women simply don’t apply.” She is currently doing a visiting rotation in orthopaedic surgery at an institution where only six of the 44 residents in orthopaedic surgery are women, and none of the attending orthopaedic surgeons is a woman. “I don’t know why orthopaedics is so male dominated, except for its connection to sports injuries. But really, we treat a whole lot of female senior citizens with hip fractures, too. Things are changing, but it’s taking time.”

Poehling-Monaghan says deciding to enter a heavily male specialty was the hard part; in terms of gender dynamics, at least, working in orthopaedics has been easy. “I’m not getting bullied. Nobody is making snide remarks or being sexist,” she says. “It’s been a great experience. Maybe it’s me—Bryn Mawr made me really comfortable about myself regardless of the room I’m in. It made me fearless. I’m so glad I wasn’t afraid to step into this.”

Making public health possible
The Bulletin caught up with Amanda Davis ’08 and Alexandra Fenton ’08 recently as they shopped for a pinata for a party in North Philadelphia. Davis and Fenton are roommates at Jefferson University’s College of Medicine, where they both started their first semesters this fall. They both majored in anthropology and minored in biology, and they both came to Jefferson because of its unusual focus on public health and primary care. Their third roommate is also a Mawrter—Zoe Ruge ’08—who currently works at the Academy of Natural Sciences.

“It’s been fantastic living with these two women while making the transition to medical school,” writes Davis. “Medical school culture is very different from Bryn Mawr in many ways. So while I’ve been adjusting, it’s been very nice to come home to the Bryn Mawr environment—supportive, open minded, and where we only talk about how we feel about our grades, not the actual number.”

Davis and Fenton both came to Jefferson for its emphasis on primary care and clinical medicine. “There’s a real focus at Jefferson on understanding the diversity of the populations we serve,” says Fenton, who is half French and grew up in France. “For example, people who live in North Philadelphia are affected by different diseases than those in the suburbs of Philadelphia. Therefore, the treatment has to be different, too.”

Both women also volunteer at JeffHope, a free clinic run by Jefferson medical students that serves special populations like

Amanda Davis ’08 hopes to work in women and children’s health. She got interested in women’s health while at Bryn Mawr when she volunteered at Planned Parenthood, counseling women about emergency contraception.
Among doctors and researchers who study HIV and AIDS, there's a name for one type of patient who always seems just out of treatment's reach: the one-visit patient. Jillian Brown '09 is an intern at New York State's AIDS Institute, a unit within the state's Health Department (Department of Health)—the only unit of its kind in the country. Medical Director Bruce Agins (Haverford '75), has assembled a bright young team of researchers, with eight interns who are Bi-Co students and a staff that includes Bi-Co co graduates.

Brown, a math major, got the job while writing her senior thesis, which shows how differential equations and population models can be used to study the spread of HIV/AIDS. She is currently working on a large project that studies how hospitals and clinics in New York reach out to patients who disappear or return sporadically after getting their HIV-positive diagnosis and never come back for treatment.

“It might seem strange, but there are all sorts of reasons that someone wouldn't come back after the diagnosis or initial primary care visits,” says Brown. “Many HIV patients are poor, and their priorities might be securing food and shelter first. Or, they might not come back if they have families to feed, or if they are living on the streets.” As of December 2007, there are 119,929 people living with HIV/AIDS in New York, and 4,301 of these are one-visit patients. One of the most common ways that medical offices keep in contact with their patients is through simple reminders in between visits, whether with a phone call or by sending out a card. But since the HIV population in New York is largely an impoverished and often homeless population, a lot of these patients don't have regular mailing addresses, cell phones, or landlines.

Other patients might have a healthy T-cell count at the time of their diagnosis, and become fooled into a false sense of security, says Brown. “They don't come back because they think they're healthy, but it might be a fluke. The reality is that if they don't come back, their T-cells will drop. This is dangerous not just for that individual, but for public health, too.”

Brown's job is to look at a huge database with information about the kinds of patients each health facility serves, how they have been trying to stay in contact with their HIV-positive patients, and whether or not those methods are working. She looks at the numbers and then calls the health facilities to talk about their procedures. The facilities she studies range widely, from a tiny clinic that serves just 40 patients in Peekskill, to St. Vincent's Hospital Manhattan that serves more than 3,000 patients a year.

“They give me their caseload info, and I look at how many of their patients come back for treatment and calculate retention rates,” says Brown. That is, she figures out which methods work, and what kinds of patients respond well to them. Brown has only been at her job for four months, and there's a lot of work ahead—“I have data from about 40 sites, and there are about 140 to go.” Ultimately, her findings will help shape new guidelines for patient retention in 180 facilities across the state.

In her conversations with health-care providers for this study, Brown says she's been surprised by how little time primary-care physicians have to discuss sexual health and ways to prevent the spread of HIV with their HIV-positive patients during routine visits. “Doctors often have only 15 or 20 minutes with each patient, so after checking the patient over for general wellness, there isn't time left to talk about safe sex,” she says. “In terms of prevention, as someone who's involved with public health, I want to help make sure that HIV doesn't spread. It's great that physicians are treating individuals for HIV, but without education on how not to spread the disease, there's still a major risk to public health. That's where my work comes in.”

Brown came into Bryn Mawr set on entering the pre-med track, going to medical school, and becoming a physician. Then she took Calculus I, just to complete her quantitative requirement, and found she enjoyed it. “I couldn't imagine not having a little bit of math here and there, so I took a couple more classes,” she says. She moved on to Calculus II, then Multivariable, and on to Transition to Higher Mathematics. “It turns out that after calculus, math becomes something entirely different than what people think when they hear the word 'math.' It's not even really about numbers when you get to higher math. It's very rigorous, using words and symbols to prove complex theorems. It's like learning a whole new language. I remember taking an English class with Bethany Schneider for which I wrote a paper about Little Women, and Bethany had to beg me to stop trying to prove everything in my paper and just explore. Higher math sort of gets into your head that way.”

By senior year, Brown was settled into her math major and looking for a thesis topic—a senior thesis isn't required for math majors, but Brown wanted to take one on. Math professor Rhonda Hughes suggested that Brown explore her interest in public health, and Brown started reading about epidemiology and biostatistics. “I knew I didn't want to go into academia,” she says. “Theoretical math and pure research weren't meaningful to me.” She approached math professor Victor Donnay about her growing interest in the spread of disease, and particularly in HIV and AIDS. “Victor was my very favorite professor,” she says. “I had taken Real Analysis II with Victor junior year, and it was the most challenging class

By Tasneem Pagdiwala '04
“It’s great that physicians are treating individuals for HIV, but without education on how not to spread the disease, there’s still a major risk to public health. To me, that’s where my work comes in.”

I’d ever taken. He made me learn in a way that I’d never learned before.”

Donnay thought about Brown’s project, and suggested she look into differential equations. Donnay is an advocate of using differential equations to analyze and solve real-world problems. They are basically mathematical “illustrations” that show rates of change happening in natural processes. A course that Donnay teaches, *Ordinary Differential Equations in Real World Situations*, looks at human problems like over-population, genocide, and the depletion of natural resources through the lens of higher math. “While mathematical models are not perfect predictors of what will happen in the real world,” he writes, “they can offer important insights and information about the nature and scope of a problem, and can inform solutions.”

Since Brown had never encountered differential equations before, she and Donnay developed a syllabus for Brown to follow first semester senior year. “He would give me an assignment, and I would pick up the textbook, figure out what he was asking me for, and present my findings the next week. I also learned how to deliver a presentation that way, and it made me a real critical thinker. Dr. Agins (Brown’s current boss) always says I’m a great critical thinker, and I always get a real kick out of that. In my head I think, ‘Thank you, Victor.’”

Brown’s senior thesis, “Population Dynamics Through the Lens of Differential Equations with Applications to the Immunological Spread of AIDS,” shows how to construct a mathematical model of population growth and then shows how population models can be explored and compared to help understand how HIV and AIDS spread through people’s bodies and, ultimately, from person to person and from place to place.

While writing her thesis, Brown began talking to alumnae in the public health field. Fuyuen Yip ’93 invited Brown to shadow her at Centers for Disease Control and Prevention in Atlanta over spring break. “After that visit, there was no doubt in my mind that public health was a route I wanted to pursue,” Brown says. And she knew she wanted to tackle public health from the viewpoint of a mathematician, not a clinician. “Early on I thought about pursuing medicine, but I decided that I wanted a career that was mathematical more so than biological. The clinician works with the individual, but without good data, there’s no way to assess what’s going on across the entire population. I’m providing the numbers so that clinicians can do their work more efficiently.”

Brown’s internship with the New York State Department of Health AIDS Institute is a year-long position. “I love the job because it reminds me so much of my time at Bryn Mawr,” she says. “Dr. Agins guides us in our projects, but it is really up to us to get them going and follow through to completion.” She is applying to Ph.D. programs in biostatistics for the fall, and hopes to continue researching the spread of disease through human populations. “I’d like to one day write mathematical research papers that the lay person could easily understand,” she says. “Because these numbers and findings—they are more than just numbers. They have meaning. They could help people in a big way.”

“I’m providing the numbers so that clinicians can do their work more efficiently.”
youth at risk, the homeless, and poor women. “Ninety percent of Jefferson students are involved with the clinic—and they are all volunteers. People fight to volunteer there, and you can only get work once every four months. That’s how popular it is,” says Fenton.

Fenton spent her gap year volunteering at Camphill Village Kimberton Hills, a 432-acre crafts and agricultural community in Chester County, PA with an unusual approach to healthcare and disabilities. The community is run entirely by its residents. Some of them are adults with physical and mental disabilities. Others are live-in volunteers, like Fenton was for a year. It was a challenging experience, she says. “Living and working at Camphill was very difficult, but surprisingly, working with people with disabilities wasn’t the hard part of the job. After a while, you finally really realize that people with disabilities are just people. You don’t see their disabilities anymore.”

Davis, a Philadelphia-area native, was very active in social services programs throughout high school and college and spent her gap year working as a clinical research assistant at the Children’s Hospital of Philadelphia. She hopes to work in women and children’s health—maybe OB/GYN or pediatrics. She got interested in women’s health when she volunteered at Planned Parenthood while at Bryn Mawr. Her job was to counsel women about emergency contraception. “A lot of women came in from a nearby college, and I was around their age. My boss thought they were more receptive to me, because it felt like a peer was telling them, ‘Hey, you should value your body, value your health, and take care of yourself.’”

As part of her work at the Children’s Hospital of Philadelphia, Davis traveled to Botswana in January with a group of clinical researchers to teach CPR to local doctors and nurses. Her work was highly quantitative, using computer-assisted feedback mechanisms to show how well or badly their teaching was going. One of the goals of the project was to create a self-sustainable education system in the hospital for basic life support. “I really grew, professionally and personally, on that trip,” says Davis. “For the first time ever, I was living with the people I was working with. That’s so different than living with other students or your friends. By the end, I had developed a whole new professional persona, one that I’m really proud of.”

Davis visited Jefferson for a pre-health conference while at Bryn Mawr, and “fell in love. It has a lot of great role models in primary care.” But both women have taken out sizable loans to fund their medical educations, and both are counting on loan-forgiveness programs to allow them to enter primary care as planned. As Fenton points out, Jefferson’s web site shows that 50 percent of its current students have taken on debts of more than $150,000 to pay for school. “Student loans are on everyone’s minds. The salaries of doctors might decrease under the health care reform, but that doesn’t mean our loans will also go down.”

At this early stage in their careers, Fenton and Davis say, the national health care debate doesn’t pop up frequently in...
EXTENSIONS IN HEALINGS

By Dorothy Lehman Hoerr

At a time when health care is a major focus in America, some Bryn Mawr alumnae are concerned with more than the traditional healing of physical ailments. Whether the impetus was a family illness, a natural disaster, or serendipity, these women felt called to do something different, something more.

Lauren Kacir ’85 recently left general pediatrics to open her own practice devoted to the treatment of Attention Deficit Hyperactivity Disorder. In her previous work with a local community clinic, Kacir found that patients had no other source of affordable treatment for ADHD. “So people started referring patients to me,” she says. “I realized I had become the resident expert.” But Kacir felt that the constraints of the community clinic sometimes interfered with patient care. “You can’t treat a challenging patient with ADHD in 15 minutes,” she says.

Her brand new practice consists of one room, where Kacir does her own receptionist work and answers all the phone calls. Although the work is tiring, she finds it less stressful than her job at the clinic. “I sleep better at night because I’m not worried that I missed something,” she explains. Now she gains peace of mind in knowing that she made a difference in someone’s life. “When I make a recommendation that actually works for a patient,” she says, “that’s what she loves about her work.

While Beth Nelson ’79 is still active in her obstetric and gynecology practice, she has added a new dimension to her life with mission work. Traveling to Biloxi and Bay St. Louis, Missouri with the United Methodist Committee on Relief, Nelson has helped to rehabilitate buildings for people in need. “I’ve done everything from washing walls and toys for a day care center the first year to measuring, cutting, and painting drywall. Last year, I was in charge of the kitchen,” she says, “and I’m not a cook.”

“I guess after Katrina, like so many people,” Nelson says, “I felt at a loss for how to help.” She recalls that a pastor from her church had talked about his own experience in Biloxi with the relief committee. “I just felt called,” she says, “and my church decided to jump in.” After a workshop with a contractor on how to install drywall, volunteers were ready to offer their services.

“It sounds kind of cliché, but you get so much more back than you give,” Nelson says of her mission experience. “That kind of hooked me.” She now plans to take at least one medical mission trip a year.

For Carol Kawecki ’76, the mission has become her primary work. In 2001, Kawecki left her teaching position in political science to become a nurse. She now works for the National Center for Healthy Housing, a Maryland-based non-profit organization. She writes, “The Center has offered me a unique opportunity to do family health education, policy development, research and evaluation in the areas of lead poisoning prevention and green and healthy building practices.”

She finds that this work brings together her teaching and nursing experience with new abilities. A project to rehabilitate the houses of in-home childcare providers in New York required her input on every decision. “Even though I’m a nurse and a political scientist,” she says, “I had to oversee everything from what kind of windows to put in.”

Still, Kawecki sees this as a natural extension of her nursing. Since nurses are trained to be completely holistic,” she says, they are concerned about all aspects of health and wellness, including the home environment. Her teaching skills are also important to her new work. “I teach courses in lead-safe work practices,” she explains. “A class may have more owners, contractors, health professionals or just interested parties who are trying to figure out how to do this work safely, and I have to work with all those interests.”

The difference Kawecki sees in her new career has more to do with outcomes. “I think the thing that’s different about teaching and nursing,” she says, “is that with teaching, you plant the seed and you’re never really sure where it’s going. Nursing is more person-to-person, and you’re able to see your effects.”

All of these women are having positive effects on lives and in communities. Nelson says of her mission work, “Even though it’s a drop in the ocean, it makes a difference to those few people.”

They would all like to see reform of our health care system. “I am absolutely convinced,” Kacir says, “that the current system is broken and we can’t continue the way we are.”

Nelson elaborates, “I see so many patients whose care is delayed or suboptimal because of insurance issues, as well as patients who have lost everything as a result of a cancer diagnosis, that I am strongly in favor of the ‘public option.’” She also points out tort reform and drug costs as areas needing change.

“My hope from the health care debate,” Kawecki says, “is that everyone is able to receive good quality medical services, especially preventive ones, at an affordable price.”

—Carol Kawecki ’76

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their day-to-day experience in med school. “Honestly, people might be a little disappointed to know how little we talk about healthcare,” says Fenton. “We’re a little removed from it, and pretty much just obsessed with passing our classes.” Davis agrees. “Right now, I’m just trying to get through anatomy,” she says.

Just wait, says Poehling-Monaghan. As a fourth-year student, she’s noticed that “this is essentially all anybody ever talks about.”

Poehling-Monaghan heard President Obama’s September 9 speech to Congress on his proposal for health-care legislation in bits and pieces, while rushing from room to room checking on her patients during a rotation. “Obama made comments about pediatricians out there doing needless tonsilectomies, and physicians ordering all sorts of unnecessary tests. Physicians around here are really upset over it,” says Poehling-Monaghan. “We expected Obama to point to the insurance companies who are driving up costs. Physicians around here are really upset over it,” says Poehling-Monaghan. “We expected Obama to point to the insurance and pharmaceutical companies who are driving up costs. Instead, he turned on us.”

George Washington University’s tuition is among the highest of medical schools in the country, and Poehling-Monaghan says this heavily influences her classmates when it comes to choosing a specialty. “The average student has over $200,000 in debt. Most of my peers have had to face the fact that they cannot afford to go into primary care. For the first 15 years after school, they would be paying off student loans. There’s a shortage of primary care physicians, but people aren’t following that path because it simply won’t return their investment. It’s sad.”

In Poehling-Monaghan’s case, her decision to specialize in orthopaedics came before the loans piled up. “I always knew I didn’t want to go into primary care, because I’d rather be the specialist than refer to the specialist. It would be frustrating to say, ‘I don’t know what’s happening, I’m going to send you to someone who does.’ I want to be the person who knows.”

Nor are the highly specialized fields of medicine, or doctors who enter the better-paid specialties, shielded from problems in the American health care system. “In orthopaedics, we’ve all seen examples of why public care is so terribly important,” Poehling-Monaghan says. “For example, I saw a woman who had a knee problem, and finds out that Medicare will pay for the surgery but not physical therapy. After a joint replacement surgery, patients need immediate physical therapy. If they can’t get it, they’re just sitting at home and getting stiff as a board. This woman’s knee freezes up, and six months later she’s in worse shape than when she came in. These are the patients who end up having a limp for the rest of their life. I voted for Obama. I work at a free student-run health clinic here. I believe we need public care.”

Wanting to speak up about health care, but not having the time

Veronica Combs ’01 rediscovered her longstanding interest in medicine while working as a care provider for a family with a special needs child. She had come to Bryn Mawr with an interest in medicine, but “didn’t like chem all that much,” she says, settled on political science and also studied finance her senior year. Combs had a long record of leadership at Bryn Mawr as a member of Sisterhood, a student representative to the admission committee, and a hall advisor.

Like many recent graduates, Combs was interested in exploring her options while applying for that first job out of school. “I wanted to make some money after college, and I liked the math classes I took in school,” says Combs. She applied for finance jobs in New York, and landed a job with Public Finance Management on Wall Street. But she quickly realized that finance wasn’t her best fit.

Combs started looking for something meaningful to do outside of the office. “I did a lot of volunteering at Bryn Mawr—the school’s program is very established, and my friends there were always volunteering for something or the other, so it was easy to do service.” On Saturdays, she started volunteering as a tutor and mentor at the Harlem Youth Center. “I would help the kids with their craft projects, or we’d go to the aquarium at Coney Island, and I realized how much I liked working with kids.”

Combs left her job with Public Finance Management after two years and decided to take some time “to just enjoy New York” before making her next career move. To make extra money, she babysat for two elementary school-age children, a sister and brother, the latter with mild developmental problems. “He was so smart—he could read, he could explain things,” Combs says. “The problem was, he’d act out in class and throw temper tantrums—he couldn’t go back to school without a supervisor at one point. It was hard on his sister when she had friends over. But he really was a sweet kid.”

Now a third-year medical school student at the University of Maryland, Combs is set on becoming a pediatrician. She says her interest in working with children traces back to her mother’s own career. “My mom taught at a school in DC, and I went to school in the suburbs. I used to go in on the weekends and volunteer there. I was very tempted to go into education at one point, but I stopped, thank God. My patience can only go so far,” she says. “But my mom loved teaching, and I knew from her that I wanted to make a difference for kids.”

She is considering specializing in the field of pediatric gastroenterology, which treats children with digestive disorders, like chronic abdominal pain and poor weight gain, and liver diseases.
Finding a way to practice medicine in underserved communities is also important to Combs, but it’s a daunting goal. “You can’t help other people if you are living paycheck to paycheck. That just leads to burn out, and then you can’t help anybody,” she says. In her view, the problem is larger than one of individual choices—it’s structural. “The cost of med school keeps going up, but salaries aren’t rising at the same rate as tuitions. This is a national problem—you can’t put the burden on students who want to help but also have huge amounts of debt. You have to give better incentives to people who want to work in primary care.”

Like Poehling-Monaghan, Combs says it is crucial for students in medical school to educate themselves about the national health care debate. She is a member of the Student National Medical Association, a large student-run organization for medical students of color. “You have to take the time to know how the issues affect you in the long term. We are letting politicians and lawmakers shape the debate, but it affects our lives and our ability to provide care.”

“I guess after Katrina, like so many people, I felt at a loss for how to help.” —Beth Nelson ’79