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* Work in Progress
LETTER FROM
THE STUDENT EDITORS

Do you remember what you ate for dinner five days ago? Mrs. X tolerated meat and potatoes without nausea or vomiting. How long did it take for your last headache to pass? Mr. Y’s resolved 30 minutes after taking 400 mg of acetaminophen. When was the last time you felt feverish? It’s post-operative day two, and Mrs. Z remains afebrile.

These are just some of the moments that make up “the progress note,” a daily documentation of a patient’s stay in the hospital. Depending on where they are in their medical training, some students have written handfuls before sunrise or while fielding phone calls and scarfing down lunch. Some haven’t written their first. Regardless, the medical profession requires that its students pay more attention to their patients’ lives than to their own.

Like patients, medical students are works in progress. Every day, they learn how and what it means to be physicians, so this issue of Agora was designed to represent the progress notes of an NYU medical student. We have arranged the works of our peers in chronological order: from the first inkling that medicine was their calling to their reflections upon graduation. In keeping with this theme, this issue also features several unfinished works — quite literally works in progress.

Even though patients are the focus of the medical profession, we hope this issue allows you a glimpse into the evolution of a medical student. Marvel at the insight they gain, remember the patients who change them, and appreciate the mentors who mold them. Find yourself or someone you know — past, present, future — somewhere within these pages.

Thanks for coming along for the (boat) ride.

— Rebecca Lazarus ’15, Daniel Mazori ’16, and Jenny Wang ’17
“Do they use thorazine?”

It’s a weird question. Weirder still because it was coming from my dad, a computer engineer his entire life who can barely remember which statin he has been taking for ten-plus years (“It’s not Lipitor — it starts with a ‘Z.’”). But thorazine is a drug that he remembers well and just its mention, I know, brings back painful memories for him. His question came as I was telling him about my first week as a medical student rotating through a locked psychiatric unit and out of an odd desire to show fraternity with me — a sort of shibboleth — he named a drug that revealed his own unfortunate knowledge of psychiatric illness.

When my dad was about the age I am now, he had already established a family. He had a stable job as part of a company on the cutting edge of the computer revolution. He had a wife, two young children, and a growing herd of pets filling the house. But signs were appearing that not all was well with his wife and soon the cycles of “feeling blue” and “feeling great” became frank depression, interrupted with periods of explosive mania: she had bipolar disorder.

As he came to terms with the fact that his wife was suffering from a severe psychiatric illness, my father was perhaps most disturbed — not by the repeated visits to the hospital (where they used thorazine to abort her manic episodes), or the unpredictable mood swings, or even the eventual dissolution of his marriage — but by the foundation-shaking realization that the 20-year-old woman he had fallen in love with could be so dramatically altered by disease before she was even 25. Unfortunately, she would not be the only member of his young family stolen by the vagaries of the human condition.

• • •

“I’m sure there were a lot of bald kids.”

This time the comment was tinged with a deeper sadness. It wasn’t so much out of a desire to show me he knew something about pediatrics; instead, given the circumstances, my dad was mustering up just as much as he could say — we both knew he needn’t say more. I was calling him from a coffee shop after my first day rotating through the pediatric cancer center at NYU. Making it to the coffee shop was itself a triumph. In case that morning had gone poorly, I had actually planned to stop in a church I know and sit down for a moment of prayerful silence. For days I had worried how the experience would go. Just the night before, I had had trouble falling asleep out of fear I would meet a patient that would cause me to lose my careful composure.

In fact, I feared a specific patient, though I couldn’t be certain she existed. Perhaps she would be 11 years old with auburn-brown hair and a toothy smile. Perhaps she would love cats, and she too would like rescuing strays. Perhaps her name would be Sarah, like my sister.

I never knew my half-sister. She was diagnosed with acute lymphoblastic leukemia (ALL) when she was ten and died six years before I was born. She was never a presence in my life, but her absence had a profound effect on my childhood. I remember the first time we ever hung a picture of her in our house. It was almost twenty years after had she died and my mother agonized over her decision to add a picture of Sarah to our collection of family photos on a particular patch of wall. When, on what would have been Sarah’s 30th birthday, my mother finally put up a picture of a sweet, disease-free nine-year-old girl playing in the sand, my father cried nearly every day for a week.

Growing up, we couldn’t have cats for pets because my father had convinced himself that Sarah’s ALL had been caused by the scratch of a stray cat named “Blue” that she had taken in off the street. When my father was told to take aspirin to reduce his chance of a heart attack, he was reluctant because he associated the drug with Sarah’s disease. Before her diagnosis, she had complained of pain and swelling in her knees, for which my father gave her aspirin. When she later developed the bruising and nose bleeds that eventually led to suspicion of ALL, my father was convinced that the aspirin had made her bleeding worse and even after myelosuppression and ALL-related thrombocytopenia were explained to him, my father refused to use or even keep aspirin in the house. In short, my father was so traumatized by the loss of his daughter to cancer that I grew to fear experiencing even a small portion of that trauma, and that fear intensified whenever I encountered sick children at the beginning of my pediatrics rotation.

I didn’t meet Sarah at the Stephen Hassenfeld Children’s Center for Cancer that day or any of the three subsequent days I spent there. I did, however, encounter several young, beautiful girls being treated for ALL. The experience for me was different even from what I expected — almost entirely because of how medicine has changed the disease. When Sarah was diagnosed, the five-year survival for ALL hovered around 20%. Today, improvements in treatment and medications have brought that number close to 90% and it continues to improve.

Sarah did not live in a time when medicine could save her from her disease, but her story survives into this new generation of medicine. My own interest in pursuing a
career in medicine was undoubtedly influenced by the telling of that story. And now, as I progress through my training, I have a profound appreciation for the impact this art can have on both the patients confronting their disease and the families watching their loved-ones fight. That may have been my greatest lesson from my brief experience at the pediatric cancer center. As an observer, I saw only bald children. As the child of a man who lost his princess to leukemia, I worried about the way these sick children looked to their parents. But as a doctor my job will be to see both the ill child and the carefree girl playing in the sand and fight to keep the illness away so that the *joie de vivre* can return.

It can be so easy to forget the good times during the bouts of chemo and all their side effects that I sometimes wonder how patients and families make it through the treatments. When the unimaginable happens and a family is left grieving the death of their child, how much harder is that fight to hold on to the good memories?

There are certain experiences of the human condition that I would never wish upon anyone — burying a child, watching a family disintegrate, bidding adieu to a loved one stolen by mental illness. Yet, as doctors, we will inevitably be party to heartbreaking moments like these at times in our careers. I can’t say I will have all the right answers to a patient suffering such a situation, but I believe I can have a healing role nonetheless.

We are frequently told in medical school that we have unique access to information our patients wouldn’t tell even their dearest loved one and this comes with a great deal of trust that our patients place in us. Patients often also see us as experts in humanity — gnostic guardians of human pathos. This, I think, gives us a power to help the afflicted family member in times of exceptional suffering. Tell him he is not alone. Tell him “This too shall pass.” Tell him you share his deep sorrow. With enough time, support from family and friends, and a focus on those good memories, anyone can recover — even from the loss of a princess.
I remember sitting around the dinner table, on our screened-in porch, in Iowa with my family — the evening’s dying sunrays casting their orange shadows into the yard through the pines that surround the garden. This could have been any summer night when the family was together, but it comes to mind now not because of the setting, but because of the conversation.

My sister Lauren was engaged and we were talking about the wedding: my dad, interested but having little to contribute; my mom, monopolizing the conversation with Lauren; my brother Robby, surprisingly engaged; and me, altogether disinterested. Somehow the conversation redirected to me and my “future wedding.” I shrugged off the hypothetical and said only that I knew Robby would be my best man. I remember it so distinctly because of the spontaneous smile and because of how proud and happy he looked that evening.

Robby and I had always been close — developing a similar sense of humor through shared experiences and interests. We often played sports, but he was born with hypoplastic left heart syndrome, so he could never train or play with a team. He had an emaciated appearance, with thick, straight light brown hair and olive-colored eyes. He was well-liked for his unique humor, developed by watching and re-watching the old Peter Sellers Pink Panther movies growing-up.

I was three years older, and he often looked to me for ideas — from creating strategies in video games to making up rules to play sports-related games outside so that we would compete against our own personal bests, rather than against each other.

At the beginning of his freshman year in high school, someone started to make fun of him for how he looked during his study hall, so I skipped part of my senior English class, and went there to just sit and talk with him. I didn’t have to directly address the issue or the individual, just hang out there with them that afternoon. The problem went away after that day.

The second time I became acutely aware of Robby’s condition was on a warm, late-spring evening, when someone from the Sunday paper wanted to interview me after a high school soccer game. I gave generic humble sports answers that are expected from a high school athlete, but on the inside I was swelling with pride from the attention. Robby and I joked about the experience, quoting Muhammad Ali’s “Imma show YOU how great I am” interview; but as he left he said with a hint of regret, “No one is ever going to want to interview me.”

I stood there for a second, said nothing, and went up to my room. Is this where I get my self-worth? I didn’t know what to do. I wanted to tell him how great he was — that he was a talented actor, could imitate accents, a comedian — but I couldn’t deal with my emotions; I felt it would be strange to talk about, and I didn’t want to make a bigger deal of the moment than it was, so I said nothing.

I had been torn about playing soccer in college, or studying biology and pre-medicine, and that night I made my choice. I never told anyone about that night before, or that Robby was my inspiration to become a physician.

Why am I ruminating on this now? Three weeks ago, while biking to church, Robby went into ventricular tachycardia. He fell, hit his head, was rushed to the hospital where he was found to be posturing, was intubated, and flown to a tertiary care center at the University of Illinois. I was at Bellevue Hospital on a Sunday doing rounds with my medicine team when I missed several calls, and finally saw a text from my sister saying, “Robby’s in the hospital.”

Forty-eight hours after the incident, my father picked me up at the airport in Peoria, Illinois with great news: Robby opened his eyes. I spent the week at his bedside in the hospital while he recovered. He had a median sternotomy to place epicardial leads for an ICD. The week went by in a blur; I was glad to return to NYC, knowing that my brother was recovering.

Now Robby is at home, completely dependent on my parents, and acutely aware of his own mortality at the age of 21. Despite the situation, he is progressing and still has his humor, dramatic flair, love of history and wants to finish his studies and become a high school history teacher.

When I think of the surgeon who cared for my brother, I recall a caring, hard working, confident, and competent doctor. That experience with my brother made me step back in the middle of my clerkship year and reconsider patient care from a new and frightening, emotional, and personal perspective.
is in the basement of the medical center. 
Where it is quiet, and cold, 
and tidy columns of white bags lay —

tired, deflated clouds lining a single corridor.

My footsteps bounce off the two picket fences of soles 
lining the way to bench 24. 
There, she waits.

I incise the silence with the whir of a zipper, 
to find she’s resting on her back,

staring up past the impregnable fortress of fluorescent 
lights, steel, and concrete
above us.

On these nights I wonder
if I am the one being studied.

Perhaps twenty-three souls, 
dawned in the sterile scrubs of the after life, 
encircle me, in tiers, along the rafters.
Careful not to step on toes, 
they shuffle to get a better look.

By the time they have settled in, 
the Chief of Medicine is asleep at home, 
and the attendings have put their pagers on their 
nightstands,
and the residents drag themselves from the call room, 
to the interns who need help with a new admission,

as I, the medical student, recite the branches of 
the celiac artery.
Riffling through the pages of Grant, 
I stand beneath the lights of this celestial operating theatre. 
Where it is quiet, and cold, 
and the ether has gathered to take notes. 
I imagine they are eager, curious spirits, 
finally discovering what they have lived on 
to create.

Emily Milam  Mt. Rainier
Shimwoo Lee  Foot
A Beautiful Death

Joshua Phelps

1

For what is not an arc, a segment with boundary, at its temporal nexus?
And isn’t that why the shadows, greys and blacks, each have different tone?
Between each one, there is another one, each in its turn undone,
And painted, with a patchwork hue, into the hills, and streams, and sun
To change in season, with the tide, as through great caverns, fern and dale,
And toward the horizontal line of pale they sink into an opening ocean,
Where at last it stills its course in its winding search for lost Elysium:
Yes, this is the fate of everything — that it should wend its way through scattered hills
In some occult, proud search, for faltering Elysium.

It melts again with the return
Of sun on northern snows, toward glacial pause, at some
Undesignated point of termination
For in the limitless
All syntax is lost, and there is nothing to be found from origin
But all things meet their source, where they are imbued with meaning, at their end.

But even as they end, they start with fresh gods out from humble dialogue
And renew their course, now effortless, through shunt or vessel tall and strong,
Now turbulent and hard, as they round sharpened turns and abraded shores
Which persist their throes so ablative,
Mourning their cold, meticulous station, that cannot last.

For neither is this larger body
Touched with immortality, but even here, and even this, at last,
At the whim of metaphysic, has its melancholy sanction.
So as we pass through layers thick with cosmologic politic,
We recognize, again, a regretful limitation:
That nothing lives Undisturbed by time, no matter its declension.
With no linguistic precedent

For eternity, rather morphogenesis of living form,
Which dies, in time, and lives in fear of an ordained demise, Is what is known.

So as with melting snows and falling blood-orange leaves on wintering branches,
So to will hills and valleys melt and whither, in ebbing phase, and lose first form, then function.

And is not death then gruesome, to take all things, and unite them in confined condition?
Or is death not a blessing still, for it begins again, and begins from its last conjunction?

2

When I last kissed her I held her long against me after
Because I saw ahead our time of hiatus
And even after, ever after, I would reach beside me, but find nothing in her place.

Was this a good death, or a shallow, broken thing?
And if I should yet go on, to what end would I promote my work
Now that the branching river had dedicated my meandering
To a different terminal than I had ever, during my long tenure, contemplated?
Was this cruelty my own, or hers, or something in the space between us, Shared and mutual?

I stood there when she left
Like a yak in a field plowed but forgotten, Waiting for rain.

3

The scalpel passes easily through unwound tissue
Severs several cords and punctures viscera,
As life is hereby transferred From mother to son;
Even as she dies, He is drawn out from her meekly pulsing folds
A newborn child, With blood, coursing wild through his veins
Describing one rotation of time’s period
Each one of them is an axis mundi, and we are each
Vasudeva at the final river,
We bring them, piece by piece, from out their decadent
shell, and offer them up
The pace is serene, the place a terminus of sacred and
profane
And this has always been the way.

The halls of science are hallowed by this cause,
that ritual which shall instill, in every case,
Each hardship and each suffering, some resolution and
some restitution, from beyond the grave.

And hence, the process of healing here is birthed from out
the bodies of the dead.

Before we removed the heart, we cut through the cardiac
plexus, and we understood
That once this was the core. This was a human being,
who had a life that could not be repaired,
And yet, from her fresh gods arose, and cried out,
“We are here, and ever have we been,
Draped in the cover of her flesh, and though we will no
longer use her name,
There is always next tomorrow, and we have no use for
sharp despair.”

Lynda Nwabuobi  Niger River, Nigeria
Will Hambley

WHAT WAS LEFT BEHIND

Seeing the face has been the most difficult adjustment. By now, I've gotten used to the exposed muscles and the grey oatmeal color of her leathery skin. But when the shroud slipping to the side exposes what remains of her face, I experience a moment of rigid silence. I can see the teeth — the worst part. The neat and pristine white rows surrounded by disfigured tissue still produce a quiet shock within me.

As I examine the rest of her body, my eyes gravitate towards certain details. Dozens of circular brown moles are scattered around as if someone had splattered her with tiny ink droplets. She must have loved the sun. I imagine her past life — long summer afternoons, soaking in the sun's calming warmth on the banks of the creek behind her childhood home.

I turn my head to briefly escape the smell of chemicals and dead tissue. My eyes are met by white walls, white body bags, the white bucket for human remains, and the flood of fluorescent light amplifying a lucid discomfort.

I hear the wail of the motorized bone saw as another student prepares to cut through her rib cage. He lowers the blade and as the saw starts eating through bone, its high-pitched cry drops an octave. A vile smell of burnt flesh wafts through the room. I stop breathing for a few moments so as not to inhale her vaporized flesh. I try to distract myself by reading the lab manual. It says to use the blunt scissors to remove the tissue covering the intercostal vessels of the ribs. I take her opened rib cage with one hand and start cleaning the messy interstitial tissue. It's strange that I think of this as "cleaning," as if she is dirty or contaminated.

My attention shifts to the powerful organ sitting perched in the center of her chest. The aorta surfaces from beneath the pulmonary vein and gracefully wraps behind the heart. Then it plunges out of sight. I discreetly place a few fingers on my own rib cage to feel the gentle reverberations coming from within. The familiar rhythm pushes back. I pick up the heart and my index finger stretches through the hollowed-out vena cava and into the right atrium. I feel like a curious toddler putting a square block through a square hole for the first time; though I don't understand all the parts, I'm filled with wonder. The two big heart valves with their tetherings look like a cluster of parachutes. The walls of the heart chambers resemble multilayered coral, woven together by the gentle hand of a sea goddess.

With my fingers interwoven into the heart's tubes and cavities, my curiosity is replaced by a familiar discomfort. This was her heart. I glance towards the face that I know is beneath the cloth covering. I remove my fingers from the heart, detaching myself from her body.

The more her body resembles our lab manual illustrations, the less I think about her. She has become the anterior intercostal artery. She has become the great cardiac vein. With each passing day a piece of her is lost to the lab manual.

The sound of metal tools clanking together as students prepare to leave brings me to my senses. It's time to stop for the day. I fold the skin flaps back into place and lay wet towels over her body to prevent her tissue from dehydrating and hardening. I used to view this routine as something almost sacred: "the shrouding of the body," as I thought of it. But it's not the same anymore. It's not as automatic to dwell upon the life of the cadaver. With enough time and exposure I suppose we can get numb to all sorts of things.

Alejandro Gomez-Viso  Skeleton Foot
She was waiting in the waiting room when I walked into the office on Tuesday afternoon. We exchanged brief hellos, the brevity secured from curtness by a mutual understanding that the principal of our conversation was imminent. I knocked on Dr. B’s door to let him know that Ms. C was here.

“Come in!” he hollered.

“Ms. C is here,” I said.

“Okay, so take her next door. I’ll see you in fifteen minutes,” he said without looking up. I closed the door quietly behind me. Dr. B was not being short with me; he was trying to teach me.

“Hello, Ms. C. Would you follow me please?” I said with a polite authority that I did not have and could barely feign. Still, with the white coat draped over me and a stethoscope around my neck, I suppose I at least looked the part. And appearances can go a long way.

The room had a small stool that stood two and a half feet below the examination table. Ms. C sat down on the exalted tissue-paper-lined furniture while I looked up at her from the only seat left, making that figurative promise literal; the patient came above all.

She waited for me to begin and I took a few seconds to select the opening words.

“So how have these last few weeks been for you?”

She sighed. “Well, I haven’t really moved all that much. I’ve been watching a lot of those law dramas on television. And I went on the bike machine in my den a few times, which was good. And otherwise that’s about it.” She punctuated the sentence with a cough. “I haven’t really found much reason to get out of my apartment. I know I should be going out more, I know I should be going to the gym, but I just don’t have the energy to go outside.”

“How about your friends? I know how much you love going out with your old dancing buddies. Have you seen them recently?”

“Sure, we all went out for dinner two weeks ago and that was very nice. But you know they all have other things going on. Mary, Pat and Charlotte have their grandchildren and their children. Betty is part of that Jewish community with her synagogue, and Anne is travelling with her husband. Rhoda is around, always calling me to get lunch, but she’s boring and always depressed. And Sally is always going into the gym, she’s made her own friends there, you know.”

She paused.

“Maybe that’s what I need,” she said picking up the thread, “a community. I don’t know, I just don’t feel like I can join something now. I think it’s too late. And the city is not a community. You say hello to a person on your block and they look at you like you’re crazy. I’ll tell you, the city is not what it used to be.”

Hearing her talk about Manhattan was like stealing a look into the past. Then, as she would have it, the city was a glorious and glittering Broadway, and if you could act or dance, you could be a goddess. And Ms. C was a goddess.

You wouldn’t know it by looking at her now. Her eyes were a faded blue and always had a bit too much fluid on their surfaces as if she had just yawned or was about to cry. Her thinning hair was orange, the work of a local beauty parlor, and was kept in place by a considerable amount of the establishment’s product. Beneath the synthetic mane was a striking absence of eyebrows, a collection of soft shal low wrinkles, an apish upper lip and a vanishing lower. In some kind of cosmic joke the years had completely inverted her body structure. Her paunch barely concealed by loose blouses tapered off into a pair of spindly legs and a sense of resignation manifested itself thickly into her general mien. But fifty years ago she would have outshined Venus.

“I used to have willpower, I used to have drive. Back when I was dancing I had real discipline. I’d exercise every day, ate nothing but healthy food. I’d go out, I’d meet people. Every night was exciting. You know, I don’t think I ever cared much about the applause, I don’t know maybe I did, but I think the main thing was that I just loved the thrill of each day, the, the… the wonder of each night.”

She gave me a sheepish smile. “You may not think so, Gregory, but I had quite a few gentlemen interested in me back then.”

I smiled back at her. “That doesn’t surprise me at all. Ms. C, I have to say, you are one of the most fascinating people I’ve had the pleasure of speaking with and I do want hear more about this but if I don’t ask you a few questions about your health Dr. B will have my head.”

Her past medical history was like the battle scars of a gladiator, the milestones she marked and paid for with suffering and blood, all of which she ultimately came to regard with a subdued pride. Malaria from her retreat to South Africa, COPD from the thousand cigarettes she dragged at with the Who’s Who forty years ago, knee replacements from her days of dancing on Broadway. Her present wounds told of no majesty. Reﬂux from binging on deli meats at midnight, high triglycerides from the couch and television mire her day-to-day slunk into, depression from the memory of how different her life once was years ago.

“You know, there are times when I get the feeling that my life now is just a sum of my misfortunes. It wasn’t years ago though. No. I guess I didn’t know it but back then time was my misfortune.”

She sighed signiﬁcantly, shifted on the exam table and blinked a few times. Her eyes glistered through the murky waters and burned with a rare clarity.
“I’m sorry, Greg. You don’t need to hear an old woman babble about vague and meaningless regrets.”

I tried my best to say something that might matter, something to console her even for a moment; I suspect I peddled from a cloying dispensary.

“Someone as kind and as lovely as yourself will always have a community ready to welcome them, will always find the happiness that is their rightful due.”

“Thank you, Gregory. That’s very kind of you to say.”

Dr. B came in a short while after. He insisted that she have a pulmonary function test. She hated that damn thing. She argued, she acquiesced; the test came back normal, she left.

A month had passed before I saw Ms. C at the office again. By that time I had been assigned a new patient and we both knew that the meeting was to be our last. We were resolved not to make a big deal of it. Nevertheless, it turned out Ms. C had some tragic news.

“Rhoda did something terrible, I’m afraid. She took a handful of pills and tried to do away with it all. Well, I don’t know if she wanted to fail or not, but her neighbor heard her ralphing or something like that and she’s in the hospital now. The doctors said she’s going to be fine.”

There was a long uncomfortable pause.

“Gregory, are you religious?”

“I’m — ”

“I am not as you know,” she said before I could respond. “But I believe that there are common morals, things that are right and things that are wrong, black and white, plain and simple. And just how could you do such a thing? What a waste, what a deep disrespect to yourself! How much must you hate life before you do such a thing?”

I didn’t know what to say. It didn’t matter. Ms. C carried right on.

“You know I never liked Rhoda. And I think I’ve begun to realize why.” She shook her head. “She is just like me in every way. She sits around on her couch waiting, just waiting for someone to call, to make plans with her. And when she does finally get that call, finally gets off her couch, she’s resentful about it. She was depressed and she made the people around her uncomfortable. Maybe that’s why she did it. She felt it somehow, knew that she had become our burden.”

A dismal cough, her inveterate sigh.

“You know, I get those thoughts too. In fact, I’m pretty sure my friends always viewed Rhoda and I in the same way. It was so different then though. All of us were gleaming nervous and giddy on those stages. We were sisters in that strange and magical life. They’re the only family I’ve ever had.

“But they all have their own families now, and in their mind I’m not really part of any of them. To them I’m just an old friend. Somehow I think they know that they’re all I’ve got. So they see me occasionally. And when we do spend time together I feel like I’m their charity case.”

She hung fire then finally let it out of her.

“I know why I can’t sleep and why I can’t get out of bed. It’s not because of the headaches at night or the sleep apnea or even the reflux. It’s because on some level I think I’ve known for a while now that there is nobody in this world who actually wants to see me. Nobody that really loves me. The world I lived and loved in passed away some time ago and left me alone. And I don’t know, but I’m pretty sure I don’t love me either.”

I wished so much that I could’ve said something, anything to comfort this beautiful woman who was crumbling before me, this woman who may need a doctor at some point but right then, more than anything, needed a friend.

I looked into her tired eyes, lined with fluid as they always were, but at that moment they were struggling like a battered levee against a flood of tears.
Shimwoo Lee  *Live Model Sketchings*
“Laaaaaadies and gentlemen! Welcome to the first day of the new season at Bellevue!”

“That’s right, Tony, we’ve got a whole fresh batch of rookies and boy, do they look green.”

“To be fair, Mark, they’ve only had eighteen months of training, although I guess if you count college and everything, they’ve had years leading up to this point.”

“Linda, what do you think? You’ve watched a lot of them during the training.”

“I have to agree with Mark, they do look pretty nervous right now, but give them a year or two and they’ll be ready to take on the world!”

The rookies hurriedly introduce themselves in the locker rooms before the morning chaos begins. Teams scurry around, dodging each other, captains striding forth with confident quickstep. Rookies fumble with their equipment, weighed down by the fear that they won’t have the right piece handy precisely when the captain calls for it. Short white coats flap awkwardly compared to the graceful arc of the seniors’ longer uniforms, belling out in the self-created breeze.

“Ok, stop. Who’s got first?”

Paper-shuffling ensues.

“Uh, I do.”

“Excellent. Please begin.”

The lead-off player is an experienced veteran, almost ready to become a captain next year, although inside he still can’t shake the butterflies that come with every opening day. He rattles off facts and statistics, air-drawing figures to illustrate certain points. All the rookies can do is keep their mouths from gaping open as they watch him expertly field the captain’s curveballs.

“Well-done. I agree that we should consult the other team and get their perspective. On we go!”

Next up is a junior player, but she’s worked with this captain before and knows what to expect. Her initial presentation is a blunt, straight shot, but the captain points out some flaws in her overall game plan. The junior takes this critique in stride and flips the question to ask about general strategies, but to the rookies’ horror, the captain turns to them.

“You young’uns are closest to your basic training…what do you remember?”

Shuffling and sidelong glances, until the bravest one pipes up.

“Well, we learned in lecture that…”

“Eh, that’s what the textbooks say, but this is real life, where nothing is like the textbook. Come on, use your brains, what do you really think about this?”

A few hazarded guesses, all landing in foul territory. More downcast looks, mentally shuffling through all the possible answers and discarding them as equally ridiculous-sounding, not fit to even bring up to the captain.

“Anyone?”

The junior steps in to pinch-hit, thanking her lucky stars that she just skimmed an article on the topic that morning while gulping coffee. Not to be overshadowed, the senior suggests sending the article to the team so everyone can read and discuss again tomorrow. The captain enthusiastically agrees and points to the rookie who first spoke.

“Would you mind doing a five-minute presentation on this?”

Gulp.

“Sure, I’ll read about it tonight and let you know what I find.”

“Perfect! Can’t wait to hear it!”

Two hours later, the team has covered a lot of ground, but the rookies are beginning to flag. In a quiet moment, one rookie’s stomach loudly grumbles its complaint. He cringes and presses the edge of his fold-up clipboard into his abdomen, as if a self-Heimlich could get rid of his body’s embarrassing physical needs.

“My, my, what borborygmi,” the captain chuckles.

“Bor-bor…what?”

“Borborygmi, a fancy word for bowel sounds, especially loud ones. I guess that should be my reminder that we’ve been talking for far too long. No matter we’re done for now, and tomorrow we’ll have speed rounds!”

The captain whirls around and dashes off, while the senior leads the remainder of the team back to the locker room. Safely inside, they sit and sigh with relief. The junior eyes the rookies, “You guys did good for your first day. Go get some lunch and we’ll go over things this afternoon.”
Arrival — 6:55 A.M.

A 60-year-old man with a past medical history of hypertension was brought in by ambulance after being found unconscious on the floor at home by his wife. He was unresponsive and began seizing in the ambulance.

On my first day of my Medicine Clerkship, I arrived at Bellevue Hospital a few minutes early to find the residents on my team. I had barely slept the night before because I was unsure about what to expect, or what would be expected of me. But once I met the residents, there was hardly time to be nervous. I followed the team on rounds, trying to make sense of the overwhelming whirlwind of patient names, histories, lab values, medication names, and unfamiliar acronyms. After rounding on the admitted patients, my resident said we were receiving two new patients. She presented them both briefly to the team: one was an alcohol withdrawal patient in the ED, the other a stroke patient in the EW.

Physical Exam — 9:30 A.M.

In the EW, the patient was intubated and placed on a ventilator. A non-contrast head CT showed a massive hemorrhagic stroke. He remained unconscious and unresponsive. Neurological exam revealed the absence of brainstem reflexes. Glasgow Coma Scale score was 3.

When I first saw the patient in the EW, I was surprised how healthy he looked. He was a thin, muscular African-American man lying unconscious in bed. If not for the ventilator, I would have thought he was just sleeping. Most of the physical exam was completely normal; his heart was regular without extra heart sounds or murmurs, his lungs were clear except for the sounds of the ventilator, his abdomen was soft and non-distended, and he had no visible skin lesions. But then there was his neurological exam. When I shined a pen light in his eyes, his pupils did not constrict. They just remained dilated, staring right through me. It was the first time I had ever seen this physical finding in a patient, and I had a visceral reaction that felt like the first day of anatomy lab. Something was profoundly wrong.

Talking to the Family — 11:00 A.M.

Just four short hours into my Medicine Clerkship, I found myself sitting in the waiting room in the EW listening to the attending speak to the patient’s wife, sister, and niece. It was the “breaking bad news” conversation that I had always heard about and discussed, but had never witnessed. Nothing can replicate the feelings of apprehension and fear in the air, the worried looks of the family members, or the distraught wife breaking down into tears when she began to realize that her husband was gone.

During the discussion, the attending explained our exam findings, the CT results, and the prognosis. He walked a fine line, comforting and empathizing with the family and making certain they understood the hard truth of the situation. It is a conversation I know I will never forget.

Brain Death — 3:00 P.M.

Brain death determination was initiated and the first examination showed brain death. While waiting for the second examination, the organ donation team was consulted to speak with the family.

While the organ donation representatives spoke with the family, there was a discussion amongst the team about what would need to be done if the patient was declared brain dead and the family consented to organ donation. I did not realize how much went into evaluating a body for organ donation and keeping all of the organs viable. It seemed ironic to me that the patient’s body would undergo more tests and receive more medical interventions once he was declared dead than he had since arriving to the hospital alive. The family ultimately denied consent for organ donation.

Moving On

The second brain death examination, including a positive apnea test, confirmed that the patient was brain dead. His body remained in the EW on a ventilator until the next day so that his son could fly in from Texas to be with his family when they said goodbye. Once the entire family was together, the patient’s body was extubated.

As I completed the rest of my clerkship year, I often thought back to that first day. Since then, I have learned a lot about medicine and become more comfortable with the day-to-day routine of working in a hospital. But my experience with this patient still stands out, in part because of the abnormal physical exam findings and the discussion about organ donation, but mainly because of how the attending was able to speak to the family. Seeing that conversation exemplified the connection a doctor can have with patients and their families, even if they only meet once. I know one day that I will be the doctor having that conversation, and when the time comes, I hope to live up to the example that was set for me on that first day.
Jason Theobald  How to Obtain Medical Records
Sticking Points

What you’ll need is a 23-gauge butterfly needle, a tourniquet, an alcohol pad, some gauze, and a few collection tubes. Gather, too, the intangibles: composure, focus, and confidence. Start by knocking politely on the patient’s door. Introduce yourself and confirm the patient’s identity with at least 2 identifiers — for instance, her name and date of birth. Explain that you’ve come to draw blood. If her eyes suddenly bulge yet her thyroid function is normal, it is probably the trickle of sweat on your forehead and slight hand tremor that have given you away as a medical student. Whatever happens, maintain your poise. Assure her that this will “only be a minute” and offer her a sincere smile, nothing too toothy. If she’s sharp, she might ask how many times you’ve drawn blood in the past. My advice is to reply tongue-in-cheek. Tell her not to fret, because you just watched a “really helpful” YouTube video on venipuncture.

After you’ve made your entrance, make sure the room has sufficient light and elevate the patient’s bed so you can comfortably access her vein without crouching. When you’re ready to apply a tourniquet, begin making small talk. Done with finesse, this helps the patient relax and gives you an opportunity to establish that elusive patient “rapport” you’ve learned so much about in Humanism 101. I like to start with a compliment—“Oh, my, what beautiful flowers you’ve gotten! Who gave them to you?” “Gosh, that’s a stunning necklace! Was it a gift?” “These are such lovely veins! Mind if I go for this one?” For this last line, position yourself carefully beyond the reach of the patient’s opposite arm — else you might receive a swift slap.

Try to locate a vein that is both visible and palpable. When in doubt, go with the one you feel. Once you’ve identified the “perfect” pipe, clean the patient’s overlying skin with an alcohol pad and request she tighten her fist. Uncap your needle and take a deep breath, then align the tip of your needle with the patient’s vein and position it at a 15-to 30-degree angle with respect to her skin, bevel up. This is usually when the patient begins to hyperventilate. (Note: you will as well, if you do not exhale after your preparatory breath. As when you are shooting a rifle, the exhalation is integral to ensuring you are relaxed and accurate.) Beware, there are no identifying characteristics of the needle-phobic. The unlikeliest patients are stoic, while their polar opposites are equally difficult to spot. An incredible hulk full of creatine and tattoos will shudder and gnash his teeth, while a tremulous 6-year-old will sit tall and still and brave. Unpredictable, indeed.

For this reason, it is crucial to provide the patient with a verbal warning prior to insertion of the needle. “OK, here comes a pinch,” is most commonly used. Whatever you do, don’t give the patient a countdown. What you think is helpful the patient may experience as sadistic. With each count, the tension builds, leading often to an anticipatory jerk at “2.” You’ll then have to begin the whole charade again, much to the chagrin of everyone involved. If your patient is too young to be distracted by verbal cues, you might ask a parent to blow bubbles. According to recent literature, early 20th century orchestra music also helps.1 If bubbles and chamber music fail you, and your patient is of-age, try a jestful promise of a post-prick stiff drink in exchange for good behavior.

On to the matter of mindset. As with most things in life, confidence is key. At one time or another, all medical students have feared being “sniffed out” by a patient for lacking confidence. If you’ll permit me a brief dalliance with hyperbole, such moments can be likened to an encounter with a grizzly in the wild. What should you do in these situations? There are a few options, chief among which are two in particular: you can keep cool, standing your ground while maintaining a “natural” stance and praying inwardly, or you can drop to the ground and play dead. In the hospital setting, the latter will likely result in an involuntary psychiatric admission, and the rest of your medical school days will be numbered. In this case, then, your only option is to stay cool. What exactly does that mean, you ask? One of my patients, a man who served a 25-year prison sentence for manslaughter, said it best, reminding me there is simply little room for error. “Imagine you’re on a beach,” I told him, preparing to plunge my butterfly needle into his vein. He looked me square in the eyes and replied, “Imagine that you are in jail and, if you mess this up, a prisoner is gonna kick your butt.”

It’s time to advance your needle. Use your thumb to draw the patient’s skin taut, anchoring her vein with your thumb one or two inches below the venipuncture site. Holding the butterfly by its “wings,” apply enough pressure to puncture the skin and pray for flash, although flash may not be evident even if you have entered the vessel. If you miss, do not pull out immediately. Rather, gently palpate the skin using your non-dominant hand and relocate the vein. When you’ve found it, pull back your needle slightly and angle it towards your target vessel. The key is to make short and rapid movements. Like spaghetti floating in a pool of tomato sauce, vessels will roll out of the needle’s way if you do not advance with sufficient celerity.

Once you’ve finally, coolly, entered the vein, collect the patient’s blood using the holder and collection tubes. As it flows, tell your patient she is “doing a great job,” but temper your zeal and resist shouting things like, “Keep going!” or “Keep squeezing!” The first patient on whom I
ever performed a blood draw—a paranoid schizophrenic who believed my resident was trying to murder her and therefore insisted that I collect her blood—offered me a gentle but pointed admonition: “Dude, this ain’t childbirth.”

When your collection tubes are filled, release the tourniquet and ensure the patient’s hand is open. Place a pad of gauze on the site. Remove the needle using the automatic retraction button and apply pressure with the gauze. If you are drawing blood from a confused or cantankerous patient, exercise extreme caution. When handling needles, the tiniest error can land you in the student health office, which is precisely where I found myself after an uncooperative patient simply flinched. In a millisecond, a “dirty” needle had pierced through my skin. Twenty minutes later, I was getting my own blood drawn and swallowing my first dose of antiretroviral post-exposure prophylaxis. Baptism by fire became baptism by nausea, headaches, tinnitus and a host of other side effects. I will not make that mistake again.

There you have it: instructions for your first blood draw, a simple yet integral aspect of hospital life. If you follow these guidelines, you’ll master the art of venipuncture in no time. Moreover, as a medical student, you’ll become more valuable to your resident and earn stronger evaluations from your attendings. Simple though the mechanics of a blood draw may be, the value is as intangible as it is foundational: trust, competence, and comfort lead later to greater skill and responsibility. Most significantly, once you gain proficiency, you’ll find yourself spending more time with patients gaining invaluable rapport-building practice. Soon, you’ll be volunteering to collect CBCs, BMPs, LFTs, TFTs, PTTs, even ABGs. And who knows? If this week your patient trusts you with her venipuncture, perhaps next week she’ll trust you with her spinal tap. We’ll save that tutorial for another day.


Noah Berland  *Dishing*
Dear Professor,

I hope this letter finds you well in both body and mind despite the taxing chemotherapy regimen you have undertaken since we last spoke. After our time as doctor-in-training and patient came to an end, I’ve thought a great deal about the time we spent together and how I failed you as the nature of your illness slowly and frustratingly came into focus.

Entering the clinical portion of my pre-graduate training, I suspected that the most meaningful way I could contribute to patient care at this stage would be through spending time at the bedside and, most importantly, listening. While I now know this to be true, I did not anticipate how much I would struggle— and at times even cower— when I began not simply to care for a patient, but to care about him as well, in the midst of uncertainty and adversity. Although I am proud of the ways in which I advocated for you and came to know you as more than a medical record number linked to a diagnostic challenge, I regret the difficulty I had in remaining a non-anxious presence in your life during the difficult days leading to your cancer diagnosis. More on that in a bit.

You may not have been aware of this, but you were the first medical patient I cared for at Bellevue. Needless to say, we were both anxious during our initial meeting, but we got off to a good start. I knew it was critical for me not to pass judgment on the illicit aspects of your “social history,” as we insiders refer to it, that the admitting house officer harped on when describing your case to me in order to transition care. Every patient has a story, and eliciting this story without bias is the most sensitive and cost-effective diagnostic procedure a physician can perform. Beyond that, it is also critical to forging the trust and mutual respect on which a satisfactory hospital experience often hinges.

I learned that you came to the United States as an emotionally troubled young man to study at a prestigious university. You claim Catholicism as your faith but spend more time with Rousseau and Botticelli than with John and Paul. You’ve held a number of professorships in your time here, and your scholarship is widely respected in your discipline. You’ve struggled over the years with depression, anxiety and resultant drug abuse.

I shared with you the story of my father. You learned that he attended seminary in Europe, after which he practiced as a Roman Catholic priest in the U.S. for nearly two decades. When the likelihood of cancer grew and your hope began to wane, you asked if you might be able to speak with Monsignor Lewellis. I know he would have enjoyed your company.

As a more practical alternative, I brought one of my mentors, Dr. Jerome Lowenstein, to your bedside for an off-the-record conversation and consultation. Several days later, as your frustration, fear, and mistrust of our ability to care for you seemed to deepen, you said little to me but asked if Dr. Lowenstein might return for a second visit. This came as no surprise to me. During my time working on the general medicine services in both Bellevue and Tisch Hospital, the moments I treasured the most— both as teaching experiences and invigorating examples of authentic, mutual connection— were the ones spent at the bedside with him. I would have asked for a second visit as well.

I suspect that one of the things you appreciated about him was his non-anxious presence— a concept that happens to be one of my father’s favorites. Building on his understanding of surgeon-turned-small-town psychiatrist Dr. Murray Bowen’s Family Systems Theory, Rabbi Edwin Friedman popularized the idea of the non-anxious presence. He believed it to be one of the keys to effective leadership within family systems that are all too often polluted by chronic anxiety. Remarkably, Friedman and Bowen’s work remains relevant to a myriad of personal and professional experiences. In the context of the inpatient medicine ward, for example, we do patients a great disservice when we fail to provide a non-anxious presence, making it nearly impossible to lead the patient through the receipt of life-changing news and the making of difficult decisions.

Unfortunately, you are likely all too aware of this. I became more anxious and less present throughout the course of your protracted journey towards a daunting diagnosis, and I ultimately failed you despite the initial progress I made by seeking to understand you as a person and advocating on your behalf for a more expedient diagnosis. As Rabbi Friedman would have said, I experienced a failure of nerve, and I can only ask for your forgiveness and promise that this experience will make me a better doctor going forward.

Thank you for being my professor. I wish you all the best.

Yours,

Stephen
Enveloped in my white coat
privileged to be given the chance to listen
I wanted to say:
*Let me listen to your stories*
*participate in the fabric of your existence*
*wear your shoes of suffering*
   along paths to empathic understanding.

Path one:
a man infected with HIV
navigates waves of depression
endures rejection from family
suffers endless pathogen invasions
   in his battle-weary body.
He takes his medications without fail
works with special needs children
has such a strong will to live
such strength humbles me
   inspires.

Path two:
a man whose mind ails him
   as much as his body —
kidney cancer, gallstones, heart valve dysfunction
could care less
   what his body is going through.
His mind wants to get out.
His wife leaves him for another woman,
his house is taken from him
he wants to restore balance to this chaos —
not deal with impending surgery.
The man fights mental battles
with reality.
I listen in awe try and understand.

Path three:
a man, renowned surgeon lives
   trapped in a disabled body.
An accident, stroke
gallstones, infections
collapsed lung, appendectomy
can't obliterate his life as surgeon, professor.
Sadness and nostalgia colors his words
   of wisdom and optimism.
He says, *words cannot compare to reality*.

Life-threatening disease
confusion, inner turmoil
loss, disability —
I understand.
I lost a loved one
to the unrelenting invasion of lung cancer.
I could do *nothing* to help fight death
to take away the suffering.

I am no different than these patients;
I breathe, suffer, relish joy, hurt.
Doctor, patient,
sufferer, healer —
   the dualism is complementary reciprocal.
Emily Milam  *Fjord Friends, Norway*
Ms. K beckoned me over with a whisper — “grab my bag, quick!” I hauled an overstuffed purple NYU tote up to her bed — it was brimming with CDs. After furtively glancing around to make sure nobody was observing her, she pulled out two CDs — the top featuring a large picture of a younger, plumper, smug Ms. K, and a title written in playful font, “How lucky can you get?” Ms. K was a cabaret singer prior to my time meeting her at Tisch Hospital; prior to an episode of cardiac arrest; prior to her new diagnosis of systemic scleroderma that, in a cruel twist of fate, had begun to tighten the skin around her mouth making it difficult for her to talk, let alone sing. My homework was to listen to her two CDs and report back if I preferred her “raw, honest” CD, or her “more commercial, big band” release. I was also instructed to hide the CDs in my white coat — she did not have enough to pass around to everyone and felt extremely bad lest someone feel left out. A few doors down, Mr. F alternated nonsensical, tragically comic babble with stone cold silence and bursts of irritation, demanding to see his now-deceased family members, at times wandering the hall trying to do so. His wife sat there next to him, forcing a smile through teary eyes when a medical professional would enter. Although her husband had forgotten little things here and there as of late, he had never before withdrawn so completely, had never before been unable to name the Giants starting quarterback. A third patient of mine, Mr. G, a former professional racecar driver, was admitted with a COPD exacerbation. Now, a lap around the hospital floor without succumbing to a crushing breathlessness was considered a huge victory. Following a particularly prolonged bout of cough and inability to breathe, he woefully chuckled, “I’m falling apart.”

His offhand statement struck a nerve. All three of my patients were falling apart. Former hobbies, jobs, and relationships that they once treasured were slipping away, succumbing to illness. As a result, to her CD title, one may argue that Ms. K was not very lucky — her body waging a constant battle against disease. Yet she remained upbeat, almost desperately upbeat. She obsessed in detail over the next concert she planned to give at her nursing home — it would have a patriotic theme. Mr. F’s mind had begun to fall apart, first slowly, insidiously, and now dramatically in episodes of delirium. Yet during his moments of lucidity, he made efforts to be, as his wife had described him, the life of the party. I mentioned I was from Pennsylvania and he immediately broke into a whistling rendition of the Pennsylvania polka. Mr. G continued daily, determined attempts to make his lap around the floor, keeping close watch on his oxygen saturation and celebrating high numbers. They all kept going.

Aside from falling into inevitable contemplation of my own and my loved ones’ mortality, the passage of time, and illness, I thought hard about what role, what positive impact I could have in the lives of these people. At the end of the day, it came down to giving them the very thing that had seemed to pass them by so quickly, the thing that oftentimes only medical students have — time. I critiqued Ms. K’s CDs, told her of my favorite tracks, and helped her plan her patriotic program. Several times I day I would take a break, sit on her bed, and have her sing me old standards. I spoke with Mr. F’s wife about his old self, about the travels they had taken, about what they still planned to do. One morning, before she arrived, I sat down and had an entirely nonsensical conversation with Mr. F — he believed that he had just cooked me breakfast, and we discussed how the phone had been beheaded and Hercules was talking to the fire department. He appeared relieved to share his thoughts with someone, and pleasantly told me he would cook me breakfast again tomorrow. Mr. G told me stories from his racing past in addition to a few dirty jokes. What they didn’t realize was that they were also healing me, allowing conversation with no hidden agenda to enter into a day filled with presentations, questions, and endless learning. Together we took a break.

Although no longer on a stage, completely mentally engaged or driving racecars, my three patients were still getting by, still finding ways to laugh, still themselves. Taking the time to listen to their stories kept their past in the present, if only for a little while longer, and I’m glad to have done that. On my last day at Tisch, I cleaned out my bag of medical documents, progress notes, and vital signs — all chronicles of the way my patients, in some respect, were falling apart. I placed their documents in a bin and was reminded again of how fleeting time truly is — how their papers will be added to a pile, shuffled away. The most important aspects of three lives well lived were not thrown away with those papers, however. Their memories, friendships, and fierce determination to keep picking up the pieces live on. All three had friends, partners, or families by their side throughout the stay. How lucky can you get?
Neelesh Rastogi  A Trip to the Clouds
Mr. F was a 78-year-old man with advanced, inoperable, squamous cell cancer of the oral cavity, metastatic to the neck. There was not much for the medical team to do during his hospital stay — mostly pain control, and a planned multidisciplinary meeting to discuss his prognosis, goals of care, and treatment plan.

Mr. F lived alone, had been unable to care for himself in recent weeks, and appeared unkempt, with a large, unsightly mass protruding from his jaw down to his clavicle. He was pleasant, but confused, with an underlying dementia likely complicating his presentation. He was fixated on the “meeting” that was going to take place, so that all his “options” could be laid out in front of him.

Although the medicine, oncology, and palliative care teams met with the patient several times to formulate a plan, Mr. F was noticeably flustered.

“When are we having the big meeting, to discuss my options?” he would ask repeatedly, despite futile attempts to explain that it was first necessary to gauge his own opinions. When probed about particular goals or questions he wanted answered, he was unable to formulate a concrete query; he would just vaguely ask about the “meeting.” I spent much time trying to help sort out the complexities and logistics of his case, but the poor man was tired, confused, and unable to comprehend much of what was happening. His biggest problem, he told me, was that his belt was ripped, and because he had lost so much weight from the cancer, his jeans were simply too baggy. The tattered belt lay on the chair next to his bed.

“I need a new belt,” he would tell me nearly every time I entered his room. Our team was busy trying to coordinate his care.

The patient’s regular oncologist was away for the week, which added to the delay and confusion. At one point, after being informed that more imaging was needed to better stage his disease and plan for radiation therapy, his frustration boiled over. I found Mr. F near the elevators, dressed in his street clothes, his gaunt fingers the only thing keeping his sagging jeans from falling down around his ankles.

“I had enough! I just want to go home and die!”

We were able to talk him back to his room, coaxed him to sit and wait. The next day, the “big meeting” took place. It surely was not the way Mr. F envisioned it. There was no big conference room, no detailed spreadsheets discussing exactly what his prognosis would be with and without chemotherapy, no clear explanation of various hospice programs. There were no family members there to support him.

We sat at his bedside in a crowded, noisy room shared by three other patients and the buzzing and ringing of monitors, the one provider who Mr. F was actually familiar with away on vacation. People he had only known for three days were discussing and planning his few remaining months. He was told that if he chose to forgo further treatment, there was a chance the tumor would grow and impinge his airway, making it difficult for him to talk, eat, and enjoy his last few months alive.

The overwhelmed, glazed look on Mr. F’s face was an amalgam of confusion, exasperation, and exhaustion. He asked few questions during the meeting — not once did he ask for an estimate of how much time he had left, and no time frame was provided.

Ultimately, Mr. F decided to return home, with nebulous plans to move in with a niece from out of state, and live out the rest of his days without further medical intervention. On our way out of the room, as we were about to start planning his discharge, he stopped us with one last question.

“What about my belt?”

The concept of patients having difficulty grasping palliative care options has garnered recent interest — one study identified several barriers to comprehension. Unrealistic expectations, underlying cognitive problems, ineffective communication, health literacy disparity, and poor integration of the various provider teams have all been shown to be common challenges in providing quality palliative care. Another study describes a stepwise approach that can be utilized when there is evident misunderstanding between providers and patient; it involves determining the source of confusion and then partnering with all members of the treatment team to build a more collaborative relationship that better addresses each patient’s needs. These strategies would certainly have proven helpful in troubleshooting Mr. F’s case. Maybe simply starting the conversation with “Tell me what you understand” would have allowed us to best meet the goals of our patient.
I get dressed in the morning and grab a belt from the closet. I think of Mr. F and wonder if things would have ended differently had his hospital stay and “meeting” been more as he anticipated. Perhaps all he needed was to be provided with some reassurance in the face of everything else that was beyond his control. I am left with the image of Mr. F leaving the hospital, shuffling down the hall, one hand desperately holding up his jeans. We never did find him a new belt.

The newborn nursery is one of the most unique places in the hospital where the admitted patients are usually completely healthy. Visitors come with “Congratulations!” balloons rather than the hopeful “Get Well Soon” cards. In most cases, families are excited to start the next chapter in their lives. They leave the hospital with more happiness than when they entered.

My week rotating in the newborn nursery ended with a drastically different day in the NICU. The fellow gave me a quick tour of the unit and short summaries on some of the patients. Amongst them was a 10-day-old infant born at 24 weeks who was fighting a severe fungal infection. Another was a child who was now over 1 month old and would likely never take a breath without the support of a ventilator. The conversation during rounds was not about whether the patient was ready for discharge, but rather about whether the family was ready to withdraw care.

We made our way to the OB sign-out, where we heard about the expected deliveries for the day to determine if the NICU team was needed for any of the births. Most of the cases for the day seemed straightforward — full term, healthy mothers with adequate prenatal care. However, there was one exception. There was the mother whose prenatal screening had revealed that her child had Trisomy 18. As I sat there, I tried to recall all the features of Edward’s syndrome that I had tried to memorize. The rocker bottom feet, the omphalocele, and clenched hand with overlapping fingers came to mind. I remembered the tip from one of the multiple-choice questions I had done earlier that week: you can usually eliminate Trisomy 18 as your diagnosis if the patient in the question is greater than 1 year of age. It’s true. About half of babies who are carried to term will be stillborn. Of those who survive, about less than 10% will be able to celebrate their first birthdays. The mother was aware of the poor prognosis. She chose to have a Cesarean section and requested for no drastic measures to be taken to support the child after birth.

The time for delivery came. We rushed to the operating room and waited anxiously. We saw the incision of the uterus, the splash of amniotic fluid, and finally — the baby. There was no cry. He was blue with a heart rate of 80. We suctioned his mouth and nose, and watched him gasp for air. We saw his intestines neatly wrapped in a peritoneal sac, bulging out of his body. We saw his spinal cord exposed on his lower back. We saw his tiny feet, bent into a position that would never be suitable for walking. We wrapped him in a warm blanket and waited. Waited for the heart rate to slowly decline. We brought him to the mother’s bedside and placed him on her chest. She asked if he would survive, and gazed at us to search for a spark of hope on our faces. The silence said it all. She wept and wondered how she would ever overcome this. The fellow whispered to me to recheck the heart rate. It was down to 30.

The cold OR made my fingers numb. I realized that I had never witnessed someone dying before. I thought about how this child’s birth and death would occur on the same bed. What could I do to help him? Airway, breathing, circulation. The ABCs of emergency that are drilled into every medical student’s head flew threw my mind. But they were irrelevant. I tried to find comfort in the idea that this was for the best. This was the only way to guarantee the least amount of suffering for this child.
Timekeeping

I did not know you until that time,
We scurried into your room
And found you pulseless, breathless, lifeless.
I was asked to keep
Time.

Fumbling for paper, I resorted to skin,
Marking the time we started to
Restore your blood flow.
Pumping in air,
Compressing your chest,
As you were infused with epinephrine,
I kept time.

Your story started pouring in,
You were post-op for an
Incision and drainage
Of your limb amputation site —
A diabetic’s fight.
Nonresponsive when a nurse returned
With the bedpan you had last requested.

Two minutes in,
With no palpable pulse.
Second epinephrine push,
I kept time.

I looked on as the team battled for your revival,
Their efforts visible by pearls of sweat
Dripping down their foreheads.
Their quick glances to me inquired if it was yet time,
With the mutual feeling that,
Every second felt longer than the one before.
With the mutual feeling that,
We wish we could do more.

Third epinephrine dose,
I kept time.

Seventeen minutes total,
The amount of time that we tried.
I wanted to hold your hand,
Your hand of already changed complexion,
From oxygen deprivation.
But what difference would it have made?
Was this desire for my own comfort, and nobody else’s?

Did you often wonder about this moment?
When would be your time?
This time unknown.
This time, your time.
This time I was honored to share with you.
This time that is now etched on my palm.

Lindy Triebes  Femur
Asha Mahajan  *Floating Garden*

Asha Mahajan  *Floating Garden Pastel*
Until I met Mr. C, I’d never had a patient die without first being part of the effort to save him. Prior to coming to medical school, I worked as an EMT in the field, and in the emergency department of a hospital. I had participated in a number of cardiac arrests, and performed CPR in supermarkets and nursing homes, in the back of an ambulance on a bumpy ride to the hospital, in the trauma bay of an ED, and in a tent on a dusty hillside in Haiti. I remember this last one most clearly.

In February of 2010, I was working at a field hospital 40 kilometers outside of Port-au-Prince. A 7.0 Mw earthquake had ripped through this tiny, poverty-stricken country six weeks earlier, and its people were reeling. Our hospital had rows of tents that housed patients; each row was a “ward” and covered by a team of doctors and nurses. At one end of the camp stood a large white tent that was the “ED/ICU.” Next to it was the smaller green tent that served as the “PACU.” Forty yards away, two prefabricated huts served as operating rooms, and a third as the radiology “suite.” Our compound had three long, thin buildings, which housed our drugs, our physical therapy supplies, and the other scant resources we had accumulated. While we had the essentials needed to perform the many orthopedic surgeries that were needed after the earthquake, we were far from a full-service hospital.

One morning, a mother arrived at our hospital with her infant son. He had been born several days earlier, at home, likely in unsanitary conditions. He was also born prematurely, although exact gestational dates were unknown. She had brought him to our hospital because he was clearly in respiratory distress, and he was not feeding. We put him in our “ICU,” and placed a peripheral IV to begin treating him. The infant was febrile, tachycardic, and desaturated while breathing altogether. But every time I checked, his heart still beat in his thin frame. So close to death, he looked like a hollowed out, former person.

Several times I placed my hand on his chest; his breaths were so infrequent that I often could not tell if he’d stopped breathing altogether. But every time I checked, his heart still beat in his thin frame. So close to death, he looked like a hollowed out, former person. Given his poor prognosis at our facility, the decision was made to transfer him.

Packed into a ramshackle pickup truck with his mother, a driver, a doctor and a nurse, they had barely made it out of the gates of the compound when the child arrested. The truck turned around; the doctor and nurse started CPR. They made it back to the ICU tent, where our team tried to resuscitate him. Immediately we ran into problems: we had no neonatal endotracheal tubes — who would think to bring them on what was essentially an orthopedic mission? We had no infant-sized bag valve mask. We had no pediatric or neonatal defibrillator pads. We improvised: use an adult NG tube as an infant ET tube. Put an adult BVM over the infant’s entire face. Our efforts failed. This very sick infant died, despite our trying everything we could to save him.

In that respect, this infant’s death was very much like every other death I’d been a part of before Mr. C. Most of the patients who I’ve helped to code have died. This is unsurprising. The survival rate for out-of-hospital cardiac arrest is around 9%. But for all these people, we — the collective medical we — did everything possible to save them. We fought death to the end, no matter how old and sick, no matter how full a life they may have lived, or — in the case of this young Haitian infant — no matter how daunting the odds.

Mr. C was the first patient I had whose death we did not try to prevent. He was in his 80s, with primary lung cancer and metastases to his liver and brain. When I met him he was very sick, and very near death. During his hospital stay he declined. He became more and more short of breath, increasingly febrile, less responsive, and was constantly in pain. The patient was already DNR/DNI, and now the resident had a discussion with his family about how close to the end he was. We gave him oxygen and morphine, and made him as comfortable as possible.

Mr. C’s family kept vigil for a few days, when his passing seemed imminent. But after several days of watching, and waiting, they could not come every day. And so he spent his days and nights alone in his room. I went in to see him early in the mornings and late at night. It was eerily quiet in his room. We grow accustomed to the beeps and buzzes of our monitors in the hospital, the calls of patients, the questions of family members. Silence becomes foreign. Alone in Mr. C’s room, I watched his ragged, intermittent breaths. Several times I placed my hand on his chest; his breaths were so infrequent that I often could not tell if he’d stopped breathing altogether. But every time I checked, his heart still beat in his thin frame. So close to death, he looked like a hollowed out, former person.

One night he passed.

Mr. C’s quiet passing was unfamiliar to me. It did not resemble the barely organized chaos of a code that ceases only when the team concludes that there is nothing left to try. It was the antithesis of the sick Haitian infant, for whom we fought against odds and against reason, until we were forced to yield. In those cases there is a moment of concession, and it is the same as the moment of death. There is an instant in which we stop trying to preserve life, and in the next instant, the patient is gone. I had trouble with the idea that there would be no such moment for Mr. C. Instead, at some point in the night, his nurse went...
to check on him and found that he had passed. But the moment when life left him went unwitnessed. His moment of concession had occurred weeks or months earlier, when he requested his DNR status.

I hope his death was a peaceful one. The loss of a life is tragic, but to code this gentleman would have been grotesque. His family had the chance to say goodbye to him — an opportunity not afforded to the families of patients whose chests thumped in their last seconds, futilely trying to fight off death. I like to think that Mr. C left us with his dignity intact.

After the Haitian infant died, a nurse named James and I carried his body to a small room. We undid everything that we had tried so hard to achieve only moments earlier: we removed the makeshift ET tube, took out IVs, peeled off telemetry pads. We cleaned him. We found a small cardboard box and wrapped him in the cleanest white sheet we could find. Presented so neatly, we invited his mother to see him. She refused. James and I used ink and a piece of paper to make stamp impressions of his feet and gave the paper to his mother. She took it wordlessly, then turned and started walking toward the gates of the compound. Away from our hospital, toward her home. We buried him in a quiet corner of the compound. The sun went down behind the mountains. I hope that this patient, too, left with dignity.

Shian Liu  Ribcage
Pritha Subramanyam

I Am Never Seen

A lonely child sits in this room
teetering at the edge of his chair ready to jump
he wants to grasp the vines draping the trees
and soar into the deep blue sky,
but he hesitates,
not knowing what lies ahead for him.

He is locked in time and space
with fingers curved to artful perfection,
dark and coarse, with an earthy quality
with fears that are immeasurable
emotions that are unspeakable.

His anger smolders, his eyes cross
his back arches, his throat closes
The world around him offers no solace
It is a trap, he says to himself.
He turns the door knob
twisting, turning, twisting, turning,
but no one sets him free.
Is there a gateway to escape? Is there a path to my freedom?

Look little boy, I whisper,
there is mom, over there;
she holds your beanpole legs to her chest
cradles your precious face until your breath slows
your nerves calm
Your life has changed in so many ways, she says,
Her furrowed brow hides her feelings
jagged lines of uncertainty etched across her forehead
frame grooves so deep
an empty oasis in an endless desert.

In that moment, you lift yourself away
from your mother’s arms
drawn by the vision of another’s hands
not quite the same as yours, but similar in color;
they are flexible and soft
they are normal.

I reach my hands out for you to grab,
a spark of recognition flashes in your eyes
a fiery flicker beneath the darkness reveals itself.
We grip each other, finger-to-finger, joint-to-joint
a meeting of two kinds; gathering of the two of us
so different and yet intertwined.

You see me as a stranger,
someone who will never know you;
I know you as the boy who is never seen
a child with a story all your own,
with so curious a destiny,
hidden by the shadows of a face
that is never free.

There is so much more to me, he says,
There is so much more to me.

This piece was inspired by a beautiful boy with San Fillipo Syndrome.
Every day I go into work with certain expectations of what the day is going to be like. Expectations of how patients will respond when I wake them before the sun has risen so I can pre-round. Expectations of what patients’ lab results and imaging will reveal. Expectations about what I’ll learn that day. And the thing about expectations is: real life can fall far short of one’s expectations, meet expectations, or exceed expectations. And no matter which way it goes — we’re rarely prepared for it.

It was week one on the floors for me. There was a call from the ER alerting my team to a new patient being admitted to the service. Our team’s resident told us a bit about Mr. X: a “62-year-old Caucasian with a long history of HIV.” As a medical student, a red flag went up in my head and I began picturing in my mind what this patient would be like. Stereotyping begins right away. Stereotypes that have been engrained via lectures, textbooks, movies, etc. And although I know deep down that not everyone fits a stereotype, it’s hard not to immediately begin imagining what the patient is going to look like based on prior learning.

And then I saw him for the first time, a 62-year-old Caucasian male with a long history of HIV/AIDS and multiple opportunistic infections, coming in for an extensive ulceration over his entire left lower leg. The smell overtook me. I had to wear two masks in order to enter the room. The lesion was unlike anything I’d ever seen. “The Leg.” That’s what this patient became known as to our team.

That day fell below expectations. I was going to be helping care for this man who I assessed was not taking care of himself; his leg appeared to be beyond repair. I was embarrassed and ashamed of my disappointment upon seeing and meeting him, but this happens — though it’s hard to admit.

Mr. X was started on antibiotics for a presumed infection overlying his chronic Kaposi’s sarcoma. I saw him every morning. We’d talk about how he felt and how his night had been; we’d chat about his life and who he was outside of the hospital. Mr. X was my patient for weeks, and every morning regularly met my expectations. Nothing new, nothing different, nothing surprising.

A few weeks into his hospitalization Mr. X’s biopsy results came back. The dermatology, oncology, and surgical services were leaving ongoing notes and paging our team non-stop. Angiosarcoma. No one could have expected this diagnosis. This aggressive vascular tumor was behind what the team came to know as “The Leg.” We ordered a chest CT, as angiosarcoma is known to spread to the lungs. The results were consistent with spread of angiosarcoma versus Kaposi’s sarcoma to the lungs. We talked as a team about what this meant for the patient’s prognosis, and either way, it wasn’t good.

I needed to leave for a meeting the day the diagnosis came in; my resident would be the one to tell Mr. X the results and his prognosis. As I walked to my appointment, I couldn’t help but think about the news my patient was about to receive, and how he was going to react. I felt it was I who was getting the bad news. The entire night I had a bad feeling in my stomach thinking about Mr. X and his reaction and feelings. What was going through his mind? On this day, I was certainly “bringing work home.”

The next morning I did what I always do — I went to see Mr. X and asked how he was feeling. How was his night? I was nervous being with him. I didn’t want to see him hurting, sad or pessimistic. As I walked in, I was met with a big smile and a “good morning!” just like every other day. I asked how he was feeling about the news he received. He responded: “Nothing’s killed me yet; I don’t expect this to be any different.”

You can never fully prepare for moments that exceed your expectations. You can be appreciative and grateful that you had the chance to experience those moments, but inherent in the idea of exceeded expectations is the inability to predict them. My patient’s positive attitude, hopefulness, and refusal to have anything but good expectations — exceeded all my expectations.
One in the NICU

Emi Okamoto

The cover on the incubator was patterned with happy giraffes, and it was hard to imagine that within that machine of tubes and beeping monitors lay a human being. My resident lifted the top from the incubator and suddenly the scene resembled a laboratory experiment. What lay inside appeared more like an infant alien than a person. A grey film pulled tautly over the body was actually skin, and the only movement was the mechanical rise and fall of the chest wall, merely an extension of the ventilator machinery. The angled arms and legs protruded oddly from the body; contractures restrained the deformed and immobile limbs. My fellow, seemingly unfazed by the patient, gently tugged open the infant’s eyelids to demonstrate the absent red reflex.

Slowly, the baby’s facial features fell into place: two eyes, one mouth, two ears, though low-set. I began to consider the situation: Is this a person? Am I allowed to question such things? I concluded, the patient was an infant and barely alive.

The role of my team was to keep this premature 33-weeker alive, diagnosing correctible problems early, and extubating her. Consults came and went — genetics, ophthalmology, neurology, cardiology — no one had any definitive or satisfying answers, just one-liners with vague, catchall phrases like “multiple congenital anomalies.”

For three days the ventilator settings were slowly weaned and we celebrated each time she was over-breathing the vent. By the fourth day, it was decided to extubate her. I watched, holding my breath as the tube came out and was replaced with a non-invasive SiPAP. Suddenly she began struggling to breathe and then quickly readjusted to using her own physiology, but within two hours she tired and we had to reintubate her, doubting whether this tube would ever come out again.

The fellow started planning, discussing pressure oscillation settings and contingency management plans. I tuned out the painful talk of ventilators. As for her future... What future? I thought. Even if this girl has a chance at surviving, her life will likely be subject to mental retardation, immobility of her limb joints, and severe visual impairment. Who would take care of her? And why? I cringed at these thoughts, and the last question shamed and disturbed me. But these thoughts were there in my mind, and reason and medical judgment could not displace them.
That same afternoon I returned to the infant to check on her. To my surprise there was another little girl in the room standing on a stool, hands and face pressed on the plastic incubator. From her profile I could see she wore a huge smile across her face. The patient's mother had come with her 7-year-old daughter, who was thrilled to see her baby sister. In broken Spanish I introduced myself to the mother, and we began talking. “Her name is Rose. Rose, like the flower,” she proudly told me. And, for the first time, I found myself genuinely smiling at the entire situation in all its simplicity: a family with a new member. With that, the infant became more than an unknown diagnosis or future prognosis.

As a medical student, I have been equipped with a vast breadth of knowledge. I can diagnose Parkinson’s from across the room. With a few simple questions I can calculate and interpret a Framingham risk score. I can thread a vein with a needle (sometimes even on the first try). The role of a physician is to help maximize longevity and minimize disease. This must hold true for any patient. Of course, there is a time for palliative care and end-of-life discussions when welcomed and warranted by the patient and family. In order to accomplish many of our duties, it is necessary to see a patient as their list of problems. Yet, what we often label as “disabilities” are simply challenges and adversities that in most cases do not define patients in society.

My mother volunteers as a part-time nurse for a severely mentally challenged child with chromosomal abnormalities. Tacked on our refrigerator are not ultrasounds or papers on interventions, but handprints and scribbles and a picture of the child beaming next to a cow on a class field trip. Former Senator Rick Santorum speaks of his daughter Isabella: five days after Bella was born, doctors told the Santorums she had an extra chromosome 18. They expected her to live hours, perhaps days. But for three years, Bella has been “a wonderful, joyful center of our universe,” as Santorum describes her.\(^1\) Even though her life has more struggles than anyone would ask for a child, her family has given her unconditional love and she is a great light in their lives.

Rose is more than just a medical mystery entrapped in tubes and walls of monitors. Though she may never even reach the basic milestones, she may never master a pincer grasp or come close to taking a first step, there is a chance she may smile and even interact with her sister.

In the past few weeks Rose’s prognosis has only worsened; her brain MRI has revealed severe periventricular leukomalacia and she remains fully intubated. Chances are she will not live past infancy. There is no doubt I will have more cases like Rose, and while I’ll give medical advice to the best of my ability, it’s not my place to say which patients deserve extraordinary measures; they deserve the best medical care I will be capable of, still remembering that better care doesn’t necessarily mean more interventions. For me, this infant represents a list of problems we will do everything in our power to alleviate. But we must remember that to her family, she has been Rose all along.

Gray skies lend the day a gloom that frigid winds better establish. You can feel it; something terrible is going to happen. The park is empty and pitiful in weather. Her fountain is dry, her trees naked, reft of color, and her marble benches chilly and wet from last night's rain. This is not a place for reasonable people to tarry on a day like today, but today, William Steven Harris thinks, to hell with reason. The only other person in the park is standing next to the fountain. His name is Mr. Brown and he is a very important person in this story. Mr. Brown is wearing a black wool hat with earflaps. His jacket and pants are black and similarly tattered. Mr. Brown is at the tapering edge of middle age, narrowing into seniority, and has all the gray hairs and wrinkles to prove it.

(His wife is on a train in Bloomsbury. She is frail and quiet, almost sullen in her shabby dress.)

But Mr. Brown's paraphernalia has caught the eye, his myriad and fluttering army that shrouds him in its black grey sea, that black grey island that stands out in the grey grayness of the day. Of course, thinks William, that man has had saner days in his life; that man has somehow integrated himself into the culture of a small pigeon community. Mr. Brown must be feeling lonely. Then William's mind wanders. Would he enjoy the company of a pigeon? They are vile things, but if you blanched their color or found albinos or ones that weren't obese and traveling in droves littering the polluted urban throng, they might even be lovely. You might even mistake one for a dove. And maybe this man can see that because maybe in a different circumstance he too would look less like a pigeon and more like a dove; after all, prince and pauper are made from the same flesh and bone.

Mr. Brown has no feed to keep the pigeons roosting and for a moment William wonders what could be keeping them together. Clouds move here and there, marbling the sky with intermittent blues as winds rush sharp across the faces of Mr. Brown and William. The gusts die for a moment and three pigeons hop up on Mr. Brown's arms and shoulders, their black feathers blending in with the beaten black fabric. Yes, they understand one another, William thinks absently. Grey grayness. The pigeons flutter and Mr. Brown shivers. They are both cold and they are both hungry on this winter day.

William hastens out of the park, takes a sharp left down Fifth Avenue, thinking restlessly of what horrors await him in his room. She would take offense at that, he thinks, smiling to himself the smile of the insane. William is in a rush, and a rush is the last place he wants to be in when he is wearing his J. Crew beige leather boots that may have been suited for everything except comfort and function. And somehow he grew fond of them.

William steps into the tawny, rustic apartment building. He walks the flight up to his unit, a paper bag of bagels and coffee in hand for Paige who will be ravenous immediately upon awaking. He stops at the heavy maroon door marked in peeling gold plastic ‘4F’. William turns the knob on the door to his room slowly, enters and finds a wrinkled mass on his bed shift, utter a soft groan, and lie still again. He takes off his boots, lifts a corner of the blue comforter and slides next to a semi-conscious Paige.

She grunts and rolls away from him. She is tired and has to shower, blow-dry her hair, squeeze into her new leather skirt, apply eyeliner and be on her way to Jennifer's Jewelry some time in the next three hours. Still, this is not the time for her emotionally needy boyfriend to beg for indulgence, and she certainly is not in a solicitous mood this morning.

"I brought you some breakfast."

She glances at the brown paper bag on his desk. Next to it was a coffee cup equipped with its cardboard sleeve, curling faint grey tendrils towards three free standing shelves, each one a foot above the other, drilled into the alabaster wall above his desk. Perched along their lengths were the classics, the formalists, the deconstructionists, the existentialists, the transcendentalists, the Romantics, the Victorians, the High-modernists, and the epistolary autobiographies of Woolf, Joyce and, of course, Faulkner. “God,” Paige thinks, “what a douche."

And, to some extent, she is right. Even William would admit it, in his careful cockney, with that smug complacency with which you plead guilty to a characteristic you secretly consider a virtue. William Steven Harris is the worst kind of autodidact, and because of that, he thinks, he is also the best kind. But a good portion of his pretensions is offset by his compassion and shyness. It was this diffidence, not his proud scholarly treasures (which, as legend has it, he covered in a drench of hail and has so broken them, so confused them) that kindled Paige's first sentiments towards him. And, while gazing at the spine of Finnegans Wake on his shelf, she broods silently upon what damage his affectations had done to her alleged affections.

“Thanks, Will, but I really don’t have time to eat right now. My boss will kill me if I come in late again. Do you have any clean towels?"

“No, well, not scrupulously clean anyway. But I do have a rather fabulous dry red towel that’s been untouched for three days. It’s quite the vintage.”

She is not in the mood for his middle-aged sense of humor right now.
“Fine,” she says, taking it from the hook hanging near his bed. She steps into the shower immediately after turning on the water. He’s probably lying on the bed with his head resting on a cocked arm, waiting, she thinks, just staring at the door. She takes her time, her rush of course being fictional, thinking of how she might broach the matter. Then, turning the handle to neutral, she thinks, well, I don’t really give a damn. Paige wraps the towel around her body and walks back to William’s room.

She begins to dress in silence. Sensing something wrong, William rights himself and asks, “Is something wrong?”

She pulls her grey blouse over her head, straightens it in the mirror hanging on the door to his closet and sighs.

“No. I mean, yes. Look, Will… You’re very sweet, and I do love you…”

The ellipsis of death, thinks William.

“But…” William prompts her.

“But, I just can’t do this anymore.”

Paige turns away from the mirror and searches William’s face for a response. It gives none. His seeming indifference is infuriating.

“I can’t be with you anymore. You scare me sometimes, your remoteness, your, your weirdness! I mean, nothing seems to excite you, nothing makes you cry, nothing makes you laugh for real. We’ve been together for ten months and sometimes I feel like I don’t even know you. I… I’m sorry, Will.”

She takes her coat in parting.

“I’m sorry.”

The door slams shut. The corrugated metal heater in the corner of his room is pumping its thick synthetic warmth in a quiet hiss. William flings open one of the two double hung windows in his room and the cold winter air steals in sibilantly. He takes off his clothes, preparing to climb into bed when he hears a loud flutter followed by a soft coo. On his small carpet that covers less than half his room stands a small pigeon. William slowly moves towards his desk, removes a bagel from its paper bagging and breaks off a small piece. The pigeon coos. William gently tosses the piece towards the bird. The pigeon hobbles towards the buttered sesame seed hunk then inclines its beak in a sharp peck. After a few moments the pigeon finishes the portion. A strange satisfaction fills William. A familiar satisfaction fills the pigeon.

William stares at the pigeon.

The pigeon stares at William.
The following account describes a recent interaction with an 85-year-old World War II veteran at the VA hospital’s walk-in clinic. This gentleman — let’s call him “Jack” — had waited through much of the morning to have his eyes examined following a recent bout of conjunctivitis, with a long history of eye issues preceding it. A generally stoic, even tough-demeanor guy, it was clear the recent threats to his vision had given him a very low threshold for coming in, even just for reassurance.

“Got any miracles for me today, doc?”

I laughed but said nothing.

“That’s what God is for,” he said in the same nonchalant delivery, “we’re just bumbling through while He does all the work.”

We were just sitting down as he finished his sentence, and in reaching a somewhat heavy religious sentiment in the few moments it took for us to get to the room, we exchanged a long look at each other, right into the other’s eyes. By letting that stare sink in, I think we both picked up on a kind of openness, that anything was up for discussion, and that maybe he had something to tell me and not the other way around.

[JACK]: “How old are you?”

[ME]: “26.”

[JACK]: “Married?”

[ME]: I let out another small embarrassed laugh. “Nope.”

[JACK]: Without hesitation, like a gun had gone off, he offered a handshake. “That’s a good man, a smart man!”

[ME]: My smile broadened, I couldn’t help it. “Well, I’m sure someday in the future… a wife and kids is probably in the cards for me somewhere.”

[JACK]: “Of course, of course, what’s better than the feeling of being hugged by a woman? But then why settle down and make one woman unhappy for the rest of your life?”

[ME]: I looked over and saw a wedding band on his left hand. “Well, you certainly were married in your lifetime, no?”

[JACK]: “Twice, with three beautiful kids to show for it. My wife passed some time ago, 28 years ago now. She was only 54, lung cancer — and this woman didn’t smoke a day in her life! I carried a lot of guilt about that one for a long time. I used to smoke cigars, every day for a little while, actually. And no matter how many nights in a row I would do it, she would refuse to kiss me!” He chuckled softly to himself, “I used to carry a lot of guilt about that one. Cosmic justice and all that — why did she get it and I didn’t?”

[ME]: “For some people it just happens, not by choice or lifestyle, just by genetic destiny.”

[JACK]: “Well that was just it, yea, it turns out there was a lot of cancer in her family — colon, lung, breast, you name it. There were a lot of losses after, it was a terrible sight. Suzie was so young, the kids were so hurt, I didn’t know what to do. I blamed God, I blamed myself, I blamed everyone. It took a long time for that ice to thaw, I was angry, dead angry.”

[ME]: “So you ended up raising your kids after that time?”

[JACK]: “Well, I got remarried within a couple years — ”

[ME]: “— now wait a minute, this from the guy who said marriage is the process of making one woman miserable for the rest of her life?” I grinned.

[JACK]: He grinned too, and sheepishly turned his head toward a remote corner of the room. “Well, don’t learn from me then I guess.”

[ME]: “I’d bet I could learn a lot from you.” He nodded, and shrugged helplessly under the weight of this fact.

[JACK]: “You gotta see, I was just a kid from Georgia who knew how to drink whiskey and pretend to chase girls when I got drafted and enlisted.”

[ME]: “Did you go to the Pacific front or the European front?”

[JACK]: “Europe — France. Absolutely no action at that time, I didn’t get out there until 1945, and by that time things had wound down. It was a real happy time, a lot of people celebrating.”

[ME]: “Did you see any combat?”

[JACK]: “Just the same ol’ stupid stories of jealous allies and friendly fire.”

[ME]: “Oh? I had no idea.”

[JACK]: “Yea, near the end there were more body bags coming from our side of the line. It was all stupidity, but they covered it all up as wartime casualties, plain and simple. But it was a lie. Maybe a preferable lie for those loved ones, but a lie all the same.”

[ME]: “Were there a lot of lies coming back from the front lines?”

[JACK]: “Some, but nothing like what we see today. The whole goddamn war, the wars in the Middle East, they’re a spectacle. I hear a lot about justice, but we kill far more innocent people than they ever could. Even worse is how
good we've become at shutting out our reality, all while the blood still spills.”

[ME]: “Why do you think that is?”

[JACK]: He pulled his former physical excitement down into a somber whisper. “Because it's easier to kill than it is to love. You look at the world today, you see all the suffering in it, you know so many out there need help, and as good-hearted individuals we feel compelled to do something about it, but our government isn't equipped to serve our highest moral callings. No, the government is there to serve us in our most primitive needs: safety, security, law and order, food, maybe a little bit of welfare. Hell, we need a lot of help even here! And that's frustrating, to the point of anger. So what do we do with all that anger? We hate, and we rage, and we murder — we murder those who we think are responsible for the world not being a better place, because it's easier to kill than to understand, easier to hate and chase demons and vilify someone else than it is to honestly look at ourselves. It's the way the world has always worked, that old bankrupt dynamic: US vs. THEM.”

[ME]: “The world can be a pretty nasty place sometimes.”

[JACK]: “That's putting it mildly, young fella. Hell, throughout the history of man it's been that way, the prevailing sins of mankind never change: greed, lust for power, wrath and destruction, gluttony and moral laziness, jealousies of all kind. The Old Testament tells us all about these. And yet, we see them play out by the hand of each generation against one another in warring nations, usually with one set of hapless young men killing another equally naïve group of men, and for what no one truly understands. There used to be wars over land and property and resources — tangible things, the things a young nation would need to grow, back in the days when the world was still large and expanding — but now we fight wars of ideology: communist vs. capitalist, Islamist vs. secular. In the end it's fear, just fear of everything and everyone that threatens their world-view, which is their safety net, their buffer from the world's ambiguities and unpredictable nature.”

[ME]: “It hurts to think about it. That we're just scared and fearful, but also violent and destructive to so many others.”

[JACK]: “Believe me, I know! I've watched it come down through the years in uglier and uglier ways, and it seems like the more we clamor about our values, the further we get from actually practicing them. The hypocrisy of killing for justice, that old bankrupt view of eye-for-an-eye, has crippled the heart and the ability to feel.”

[ME]: “What do you see as our way out of this mess?”

[JACK]: “I spent many years without God in my life, and then one day I really heard the story of Jesus, and let it into my soul. I don't mean that in any sense of literal salvation, that's someone else's business to figure out. All I know is what's written about the man's life, and the way he lived it, and that was always with one ultimate truth: Love. To love and be loved, and to love even your enemies in a sense of deep compassion. That's what will save this world, that's what has saved my world for 85 years—not angels looking over me, or fighting demons in Europe, but just the simple sense of meeting the world with love. It's a power that brings us closer to one another, and in that way, closer to God, whatever that may be. Our only solution is love.”

We met each other with another long glance, with another long silence to follow it. I don't believe either of us expected that connection, and it took us time to reorient back to the eyes that brought him here. But there was no way to truly leave that indelible moment. It was his presence, as well as mine, in that room together, really open and ready to hear something. And that it was said. It was a message of love.
I never know quite what to say when they ask how I’m doing each morning.

A part of me is relieved, because it’s morning and I’m cuddled once again in a cocoon of sunlight, safe from the terrifying moments in the darkness before I fall asleep each night. That’s when all of my worries and fears come creeping around the hospital curtain, when my parents and friends have left for the day and I have only the suffocating pitch black and the unrelenting solitude and the “what if” questions. They make for poor company.

Another part of me is enraged, because again this morning I’ve woken up, stretched my arms, breathed in deeply, and attempted to wiggle my toes, only to find two immobile, heavy, helpless legs that refuse to move. I can feel every fold of the sheets and blankets of my bed, can feel how my calves are longing to tense and to relax, but I cannot make them move on my own.

The funniest — and scariest — part of all of this is that I didn’t come to the hospital because of my legs. I came because I was having fevers, fierce ones, up to 103, 104 degrees many days in a row, and my mother was tremendously worried. “It’s your lupus,” she concluded, “we need to see the doctor.” And so we went to the hospital, and they blasted me with lupus drugs, and my fevers went away. I was on the up and up, preparing to leave the hospital and return to my apartment on the Upper West Side, planning a seamless return to my job as an elementary school administrator, when these issues arose.

I fell one day, in the bathroom. It wasn’t so much the fact that I fell that troubled me, but that I couldn’t get up, trapped foolishly on the restroom floor by uncooperative legs, until I called loudly enough for the nurse to hear me when she was walking by. Later that day, I began to notice that I couldn’t urinate properly, though I felt the urge to do so. My bladder felt like a water balloon at the end of a hose, growing larger, stretching thinner, becoming more and more uncomfortable, but nothing would come out. When I finally told the doctor and he suggested we use a Foley catheter, more than a liter and a half of urine filled the bag. Holy cow.

After the fall in the bathroom, my legs became weaker and weaker, until I could no longer move them on my own. Troubled, the doctors took an MRI of my brain and my spine. What they saw surprised everybody; “lesions,” as they termed them, across several vertebrae, where the myelin of my neurons had worn thin. A “pocket” within my brain, pushing on the structures, composed of unknown material and of uncertain etiology. They weren’t expecting such findings, but now, since they clearly existed, could the doctors explain them? As of yet, no.

It’s been more than a week, and I still can’t move my legs. That terrifies me, because the doctors have tried all sorts of things to cure what they refer to as my “neurological deficits.” Strange things, like putting a catheter into my neck, giving me treatments such as “plasmapheresis” and “IVIG,” and one infusion after another of steroids.

On the other hand, I feel reassured, because it’s nice to know that the medical team cares. I’ve gleaned from the varying reactions of my (revolving door of) hospital roommates that the sea of white coats can be either comforting or isolating. I appreciate the daily check-ins, the parade of consult services, my rheumatologist and my hospital team, because it’s encouraging to know that they’re working their hardest to find out how to help me. A gnawing feeling in the pit of my stomach tells me I might need them to pull out all the stops to fix what’s going on, and I’m strengthened by the fact that the doctors seem so determined to find a solution.

I’m also thankful that their voices don’t convey pity when they ask how I am each day. Can you imagine? The medical student can’t be more than a few years in age from me; same with the intern. Hearing them feel sorry for me would immediately separate us; it would establish why I’m in the hospital bed and they’re not. Three weeks ago, we were both walking just fine. I’d rather not be reminded of how my life has changed so dramatically, and so rapidly, leaving such an unnervingly uncertain future. Compassion is fine, empathy is welcome, but not pity. It is hard to keep my spirits up, despite the cheerful words of my parents, the insistence that “we’re just waiting for the treatments to kick in.” Hearing drops of sympathy sprinkled amongst the words of my caretakers — any of them — would lead to my own resignation, I’m sure of it. But I won’t accept any of that right now, not from my doctors, friends, or from myself, because feeling sorry for my “circumstances” is, in my own view, the first step to giving up. Hearing the same resilience in the voices of my medical team emboldens me.

So I guess what I’ll tell them today is this: Good morning. Yes, I slept fine, though it’s always hard to sleep well away from home, you know. No, no real changes in my legs since yesterday. I know, I’m disappointed, too. At least it’s not any worse today, right? No, no tingling, I still feel you poking at my toes and tickling my feet, that’s good. Thanks for stopping by today; I’m glad you came. What’s our next step from here? I’m ready for it.
Robert Spencer

Worst Nightmare

He readies himself, breathes deep, gathers composure.
You are a doctor, says the inner voice.
His hand pulls the curtain aside, his body enters the room.

You have Stage IV lung cancer, he tells the patient,
and waits for tears to trickle down the man’s cheeks.

One year, he continues. That’s how long you have to live.
The man stares at the student with an expressionless face.

What say you, Mr. Jones? Asks the student.
The man seems unfazed. Perhaps confused. The student falters.

Mr. Jones, do you understand what I am telling you?
The patient’s mouth slowly opens, the student shifts,
assuming the posture of compassion.
The mouth speaks, gently:

Sir, I am not Mr. Jones… Mr. Jones is in bed 34B.
Dear Dr. Doe,

As I assimilate into my role on the medical team as a fresh medical student, I am utterly aware of my inabilities and knowledge deficits, so I follow instruction as expeditiously as my amateur mind can process it. I am acutely aware of the people on our team, and the various levels of leadership each person assumes in this civilian, yet militarized, medical chain-of-command.

From the intern who guides the medical student and connects as the authority with their patient, to the resident who guides the hourly struggles with the team, to the attending who imparts their wisdom and makes the ultimate calls, I see leadership at every level of training. I see that attending physicians are called to be leaders. They guide the healthcare plan of the patient, set the tone for the treatment team, and pioneer the frontiers of their field with research. Patients, junior medical staff, and peers all see the attending in the light of leadership.

Perhaps learning how to lead involves learning how to follow. In order to be built up, one has to be broken down. Clerkship year has been a lot of breaking down — of pre-tenses of pride the first year-and-a-half of medical school didactics did not manage to penetrate. Clerkship year has collapsed any preconceived lofty notions of what it means to actually practice medicine and serve patients. Is there glory in examining a sacral ulcer or decompacting fecal impactions? The practice of medicine, I am learning, is service at its core, to your patients, to your subordinates. Maybe the glory is found in the humility of the leader, who after years, can look at any person on the floor and find them worthy of their time.

One of the most precious, non-medical concepts I am learning this first year on the wards is what I like in the leaders I admire, and what I dislike in the leaders and find challenging to respect. I want to remember what it was like to be a follower one day when I am a leader. I propose to look at the fruits their character produces. Are they the essence of patience and kindness? Do they encourage the object of their scrutiny towards the answer; do they encourage their patients? Can they inspire and enlighten? Do they bring light to an area of my mind that was dark?

In your own medical training, do you remember that intern, who sat down with you for 15 minutes to review a case? Remember how he asked you questions, and rephrased his questions, until you knew the answer? When you got the answer wrong, he blamed himself for asking a poor question — what humility. He saw the answer inside you even when you did not, and chose to walk with you through the clinical story. He helped you retrieve the causes of acute renal failure in your mind; because of the process, you have found that knowledge forever. He did not hastily rattle off the causes or just populate a list of possible etiologies. He invited you to think. He guided you to consider it the way a clinician would. Remember how grandiously and patiently he led you to the answer.

Perhaps you remember that resident you worked with on that abstract? Sure you did some grunt work for it, and came up with a paragraph of words coherent enough to call a draft. But remember how she tore it apart with kindness, reworked the entire abstract, and submitted it on your behalf? In encounters with a great leader and mentor, you might be left with a greater sense of your self.

Or do you recall how on your second day on internal medicine, after a particularly circuitous morning of rounds, your attending walked everyone to the cafeteria and bought the whole team a round of iced coffee? You needed and appreciated that dark, icky coffee not just for the caffeine, but for what it symbolized. When you as a leader demonstrate your consideration and prodigality, it frees your followers to give even more.

And among all the doctors with whom you interacted, remember the ones who treated their patients exclusively as medical puzzles. Who are we really serving when we practice medicine? Is the patient’s care the primary goal of practicing medicine? Or is patient care sometimes simply the byproduct of our drive for success or our pursuit for intellectual righteousness? One physician emphasizes the importance of competence and compassion in a doctor. He argues that both “competence and compassion need to be developed simultaneously, as the giant oak develops its root system along with its leaves and branches. Competence without compassion is worthless. Compassion without competence is meaningless. It is a great challenge to competently and compassionately guide one’s patient…” Reflect your competence in your skills and knowledge. Reflect your compassion in your kindness, sincerity, and concern.

You set the tone for your team. Compassion must saturate the core of your authority. The author of The Wounded Healer explains that through compassion “it is possible to recognize that the craving for love that people feel resides also in our
own hearts, that the cruelty the world knows all too well is also rooted in our own impulses.” You are not perfect. Some of the people you meet, work with, or treat, you may want to hurt — or worse, ignore. But have compassion so that bitterness is not perpetuated. Step outside the cycle of acrimony so you can fully step into your role as a healer and a leader. Even if compassion is scarcely reciprocated by your patients, your subordinates, your peers, never cease to give it.

You are a doctor, a leader, an officer in this battlefield of medicine. Victory is so much more than just outcomes. So Dr. Doe, this letter comes down to one question: did you become the doctor you wanted to be? Remember the elements of leadership you admired, and remember those that you did not. I know this letter will take on different meaning to you at different stages of your career, but please remember, it is never too late to be the doctor you always wanted to be.

Very respectfully,
Jane Doe, MS3
