

HEAL

Humanism Evolving through Arts and Literature



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COLLEGE OF MEDICINE

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LETTER

from the Editor

I am especially excited to share this twelfth volume of HEAL as it represents our return to print after two years of navigating COVID-19. While we were unable to print our paper edition during this time, we endeavored to foster artistic reflection within the FSU College of Medicine community and beyond, continuing to serve as a creative outlet when needed most.

Creative expression can be a powerful way to process traumatic upheavals, stress, pain, or other frustrations in life. With this in mind, HEAL released a special digital issue in the summer of 2020 dedicated to our community's creative response to the pandemic. The art, music, and writing we received demonstrated resilience and camaraderie amidst the difficult navigation of the unknown. You will find many pieces from that issue included in Volume 12. Of special note is "Contagion" by Dr. Michelle Nguyen, which reflects on the racism against Asian Americans at the onset of COVID-19, and Dr. Kevin Reyes' musical composition "Calm."

In the summer of 2021, HEAL and the Chapman Humanities and Art in Medicine Program partnered with the University of Arizona College of Medicine to conduct a bilateral Graphic Medicine workshop for faculty and students. "Graphic Medicine" describes the growing use of comics, or graphic narratives, in health sciences education, narrative medicine, and patient care. At the end of the workshop, attendees were invited to create a comic depicting an experience related to the pandemic. Three comics produced at this workshop are included here, including one by our own Susan Epstein, entitled "Being a Medical Librarian During COVID-19."

Volume 12 also contains the winning essays from *both* the 2020 and 2021 Humanism in Medicine Essay Contests. Each of the six winning authors share moments in medicine where they witnessed exemplars of humanism, or learned the value of true humanism through personal experience. All of these essays encourage us to practice compassion, respect, and empathy in our daily lives.

Many of the essays, poems, and art within Volume 12 also serve to move us beyond the pandemic, showcasing what more there is to consider. I found Pam Anderson's narrative about her experience living with hyperhidrosis especially moving. Beth Appleton's vibrant cut paper art also brings joy and hope. Her "Stardust" was inspired by December's Geminid meteor shower and a desire to send out "bright wishes for the new year ahead."

Please enjoy Volume 12 of HEAL, and may you find comfort, awareness, and healing in the pages that follow.

Warmly,
Tana Jean Welch, PhD



On the Cover

PEACEFUL MIND

Chaitali Umesh Hambire, MDS

Dr. Hambire is a certified specialist in Pediatric and Preventive Dentistry. She has been a passionate practitioner and teacher of pediatric dentistry for over 15 years.



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MEDIA

DAYS, WEEKS, MONTHS

Brooke Lajeunesse, MD

I recount the day over and over. What did we do right? What made this man live? Did my hands actually bring someone back to life? Everything I do from now on will be a challenge to match that frightening and rewarding day. Not a day, actually, a week. And for my patient, months.

It was the Monday of my second week in interventional cardiology—which was not my first choice of electives, but an elective that would benefit my future career in Emergency Medicine, so I was content. I was rounding on my patients that morning when I got a call from my attending. It was odd for him to call; he usually just texted, so I knew something was wrong. When I answered, all I heard was “Meet me in Trauma 2, stat!” then he hung up. My heart racing, I shoved my phone in my white coat and flew down the stairwell, two steps at a time. As I approached the ER hallway, my attending flashed by and threw open the ER doors. I picked up the pace and ran after him while mentally preparing myself. I thought, “This is interventional cardiology, Brooke, get ready because you’re about to be doing CPR.” I was right.

When I got to Trauma 2, I was met by a gaggle of nurses and paramedics, throwing wires every which way and starting IVs. The patient was a 60-year-old male who began experiencing severe chest discomfort at his home. He called 9-1-1 and was transported to the hospital by EMS. En route, he was found to have an anterolateral ST-elevation myocardial infarction. Just minutes prior to arrival, he coded. Paramedics started ACLS which included several defibrillations and rounds of epinephrine. When I stepped in the room, I recognized the paramedics from my EMS rotation. They looked at me as if to say, “Welcome back to the party, Brooke!” The “party” was running a code in the back of a speeding ambulance, which we did on several occasions.

So, once again, I entered the “party.” My attending looked at me and said, “Get on that chest.” I grabbed some gloves and took over compressions. “Push hard and fast,” I could hear the American Heart Association instructor in my head. The patient was purple from the chest up, his eyes open with the 1,000-yard stare. I wondered if he could see anything, think anything. He was diaphoretic and cold. I thought back to all the times we coded someone in the ambulance and they looked like this, the whispers of the paramedics saying “he’s super dead” or “no way this guy has any brain function left.” I couldn’t help but think the same thing. He had already been down for 20 minutes; the outcome couldn’t be good. I pushed hard and fast, taking turns with a nurse, both of us fatigued. My attending obtained femoral artery access in anticipation for cardiac catheterization. As he held pressure on the femoral artery, he also assessed for a pulse.

I continued compressions, feeling the sternum crack under the weight of my body. That was a first for me and definitely not my favorite feeling in the world. Suddenly, my attending yelled, “Hold compressions!” Seconds, which felt like minutes, went by before he said, “We got a pulse!” I couldn’t believe it; our team had gotten a pulse! In the following minutes, we worked quickly and carefully to prepare the patient for transportation to the cath lab. The elevator was being held and my attending and I rode the gurney through its doors alongside our patient. The catheterization procedure was touch and go, but in the end, he made it through. An Impella device was placed to take some strain off his weak heart, and he was moved to the ICU for further care. My attending and I returned to business as usual and went to the ICU later that afternoon to check on our patient. When we arrived on the ICU floor, we were greeted by our patient’s nursing team exclaiming, “Your patient is awake and responding to commands!” I could have cried. This was not my first experience being

part of a code. It wasn't even the first time my code team had gotten a return of spontaneous circulation. But this was the first time I had ever seen my patient wake up fully oriented. Even my attending was amazed. Then it all hit me. I was a part of that; I helped bring this guy back to life. How often will I get to see that?

The most rewarding part was that this was my patient and I got to see him every day until he was discharged. I witnessed the physical, mental, and emotional impact that cardiac arrest has on a person. Every day was hard for a different reason. Day one, my patient had to be intubated, sedated, and placed on hypothermic protocol. Day two, more of the same plus his kidneys began to fail resulting in the addition of continuous renal replacement therapy on day three. Day four, when I placed my stethoscope on his chest, he opened his eyes and looked at me. This was the first time I really saw his eyes....ice blue, cold and scared. His eyes were wet with tears. I felt his fear deeply. He was still intubated so he couldn't speak, but he could shake or nod his head to "yes" or "no" questions. He could hear me. He could understand me. I wanted to comfort him in any way I could, for this man was a miracle.

When I went to round on him the following Monday, he was awake, sitting up in a chair, and picking at his breakfast. I expected him to be cheerful, grateful with a second-chance-at-life demeanor. Instead he was sad and tired, even with family at his bedside every day. I was frustrated. We worked so hard for the last week to keep him alive, so why wasn't he relieved? Then I realized this man's body was put through the wringer. Now was not the time to "fix" him, but to support him and lift him up. He was facing a long journey ahead—months of recovery, lifestyle changes, follow-up appointments, and lifelong medications. Although it will take time, I hope one day he sees the miracle I see. He came through the hospital doors dead, but rolled out alive. The paramedics, nurses, doctors, and therapists who cared for him had saved his life, and he in turn, had given all of us hope. We hope that as physicians, we can change lives, even save them from time to time. As a third-year medical student, I got to be a part of saving this man's life and I will never forget this feeling of hope. ▪

Dr. Brooke Lajeunesse graduated from the Florida State University College of Medicine in May of 2021. Dr. Lajeunesse is a PGY-1 Emergency Medicine Resident at San Antonio Military Medical Center and is currently serving as a Captain in the United States Air Force.

The Privilege of Another

Bryan Pacheco, MD

I feel it has been months, love,
and you're far, dreaming something new,
but I've been here all this time,
in our living room, away from you.

Glancing looks at these pictures of past,
of what we love most,
I think I feel your hands in my white coat,
you make a most beautiful ghost.

And I know that this glow is the pale moonlight,
oh, I adore how it bathes your skin.
I've missed all these meals waiting,
I hope you forgive me for a late check in.

Give me a few hours, to continue this trekking on,
to my heart and our plans;
truth is, while you were saying goodnight,
I had memorized facts about parotid glands.

I hope you don't mind living this double life,
I just need a little more time,
because all I endear is built between us
and losing you would be my greatest crime.

Dr. Pacheco graduated from the College of Medicine in 2021 and is currently a preliminary surgery resident at Case Western/University Hospitals Cleveland Medical Center.

A photograph of ancient stone ruins in Cambodia, heavily overgrown with large, gnarled tree roots. The roots are light brown and intricate, forming a complex web over the dark, weathered stone structures. The background shows lush green foliage and a clear sky.

FORGOTTEN BY TIME IN CAMBODIA

Randall Fisher, MD

Dr. Fisher retired from a career in medicine and surgery of the foot in late 2017. He discovered his passion for travel while still in his teens, and thus far has visited approximately 65 countries, always with camera in hand.

Remember Me

Sadhika Sood

Will I be remembered?
When my soul bids adieu
to this transient body of sins
When I no longer am part
of this fickle land of whims

Will I be remembered?
When you no longer find me
sitting in this chair
And my sound doesn't echo in this house
coughing and gasping for air

Will I be remembered?
When my musty scent goes missing
without a trace
Or will my sickness haunt you
and be all that remains in my place

So tell me, will I be remembered?
For what I was
For what I am

I reckon not, nor do I desire
to be this lasting memory
My only wish—
to be remembered fondly
as I'm lowered down into the ground

Sadhika Sood is a recent MBBS graduate from Kasturba Medical College, Mangalore, India. She is passionate about narrative medicine, medical ethics, and wants to make significant contributions to medical education & healthcare management in her long career as a physician-scientist.

COVID

My dad died last year as a result of what I call “COVID Cascade.” This is my nomenclature for the series of unforeseen consequences that ensue when COVID-19 breaks out in a healthcare facility. My father did not have the virus at the time he died—in fact, he tested negative three times. I write this hoping it will raise awareness in other families of the sometimes invisible dangers posed by the COVID horror.

I have been a professor and consultant in the healthcare industry for over 35 years. Prior to the pandemic, my brothers and I drew on my experience to get our dad as well-situated as possible. He was 91 and had debilitating Parkinson’s, but not the dementia that is so often comorbid. An ex-Marine, he was alert and often made incisive remarks about the political climate in the era of the pandemic. Thanks to dad’s wise investment in a generous long-term care insurance policy, we were able to pay more to keep him living in a “skilled rehab unit” that mostly housed elective surgery recoverees. This unit, within a large nursing facility, attracted a talented staff who were retained for years at a time, quite a rarity in long-term care. While the rest of the building had a typical residents-to-caregiver ratio (pre-pandemic), my father’s unit had about 30% more staff on duty allowing him consistency of care. He was the only “permanent” resident in that section. We made sure he had additional speech and physical therapies that were available. After March of 2020, when all visitors were banned, we taught the activities staff to turn on a Zoom conference and let him chat with his loved ones a few times per week. Zoom allowed him to “travel.” Through screen sharing, he attended live Easter Mass at St. Patrick’s Cathedral in NYC, and saw my grandmother’s irises in full bloom where they had been transplanted into my garden two states away. He was a bit bored with no more live sports on TV, but he was as well-attended as possible.

All this changed as COVID-19 surged in his county. The circumstances of the outbreak in his facility are extraordinary. In contrast to most nursing home plagues reported in the media, with common rates of about 40 infected patients to 4 infected staff, my father’s building

had about 20 infected staff and only 4 COVID-19 positive patients. Since the facility locked down in early March, with no access by anyone except residents and staff, it seems clear that the patients acquired the virus directly from their caregivers. The facility—like most in the US—had no ability to acquire N95 masks with superior particulate filtering. And yet, as one of my loved ones trained as an infectious disease doctor stated before everyone caught on: “This virus spreads through the air like tuberculosis.”

The effect of the outbreak was to isolate my father from his usual care. With elective surgeries canceled, my father’s large, free-standing unit was no longer financially viable. His long-term caretakers were reassigned, and his nearby nursing desk shut down, replaced by a new “COVID Unit” with a Plexiglass-type barrier to direct airflow away from his room, leaving him alone at the end of a now irrelevant corridor, without even so much as nearby foot traffic by his known caregivers. With the word of the outbreak in the local media, the facility reported an inability to recruit and retain adequate temporary staff.

Word came suddenly on a Monday night that he had fallen in his room. Reaching him by phone, dad said he had just wanted someone to close his shades against the summer light so he could go to sleep early. But he said nobody ever came for his call button anymore. His former staff kept his walker placed where it was readily available to him at all times. And yet dad thought he would be able to maneuver himself to the window and back without it. He was found on the floor by the shade pull.

Believing his hip was merely bruised, a nurse and a covering resident at an affiliated hospital recommended ibuprofen and acetaminophen so Dad wouldn’t get “loopy.” Dad was lucid, making self-effacing jokes, and asking whether he should be transported to the emergency room. A staff member said to me on the phone that night: “I feel badly, those last few patients left on the rehab unit have really been neglected.”

CASCADE

We agreed that rather than assume the risks of transporting him to the hospital late at night, in the morning a mobile imaging machine would be brought in to assess him.

KILLED MY FATHER

Helen Meldrum, EdD
Bentley University

I called the staff by 5 A.M. Tuesday and was told he had slept well. But when I called again at 8:30 A.M., staff reported he did not want to eat or drink, and “looked bad.” On the phone with me, he could not make himself understood well and seemed to be out of breath. From what I now infer, he went downhill very fast from that point onward.

Many families have recounted in the media the heartbreaking COVID rules in nursing homes, which dictate only one 30-minute “compassionate last visit” while fully masked and gowned. I received my pass by e-mail at about 12:30 PM and began the over 2 hour drive. I entered the facility just after 3:00 PM and found dad trying to respond to me, but in abject pain. Nobody had given him morphine or anything stronger than an NSAID. I went into fiercely protective mode. I asserted that he needed morphine now, as the facility physician walked up behind me unbidden and started touching my back and shoulders. He weakly offered: “Maybe I’ll be able to get a time-released fentanyl patch for him at some point?” A social worker tried to get me to leave, as minute number 31 was ticking by. I remembered and asked for their facility hospice coordinator by name. Due to COVID, she was forbidden to walk over immediately from the section of the building she was in, but she rang my cell phone. I knew of a beautiful freestanding hospice house nearby she was affiliated with. I said I wanted dad transferred there immediately. She replied that the hospice had strict rules not to admit COVID exposed cases lest they endanger other dying patients and their staff.

Due to the outbreak at Dad’s facility, the state CDC had prioritized extensive testing on site. My father had just had three recent negative COVID tests and lived alone quite abandoned in his private room. This documentation was his only passport out of there! When the social worker tapped my shoulder again, insisting I was past my 30-minute compassionate visit deadline, I replied, “When his transfer is arranged, I will walk out of here.” And so, it happened.

In the COVID era, only two people were allowed to be with my father in his lovely hospice suite, myself and one of my brothers. They kindly allowed Dad’s favorite “granddog” in too. Just in time, as there were already plans to start banning dogs because of the first documented case of canine COVID in the US. We three kept vigil in his quiet room. Staff looked the other way when we bent the rules, opening the window to let him smell the summer air.

Once he was comfortable on medication, we “love-bombed” him continuously all day Wednesday into Thursday. Telling him he was the best dad ever. A modest and polite man of his era, he never liked to be fussed over, but we could see him mouthing the words, “Thank you.”

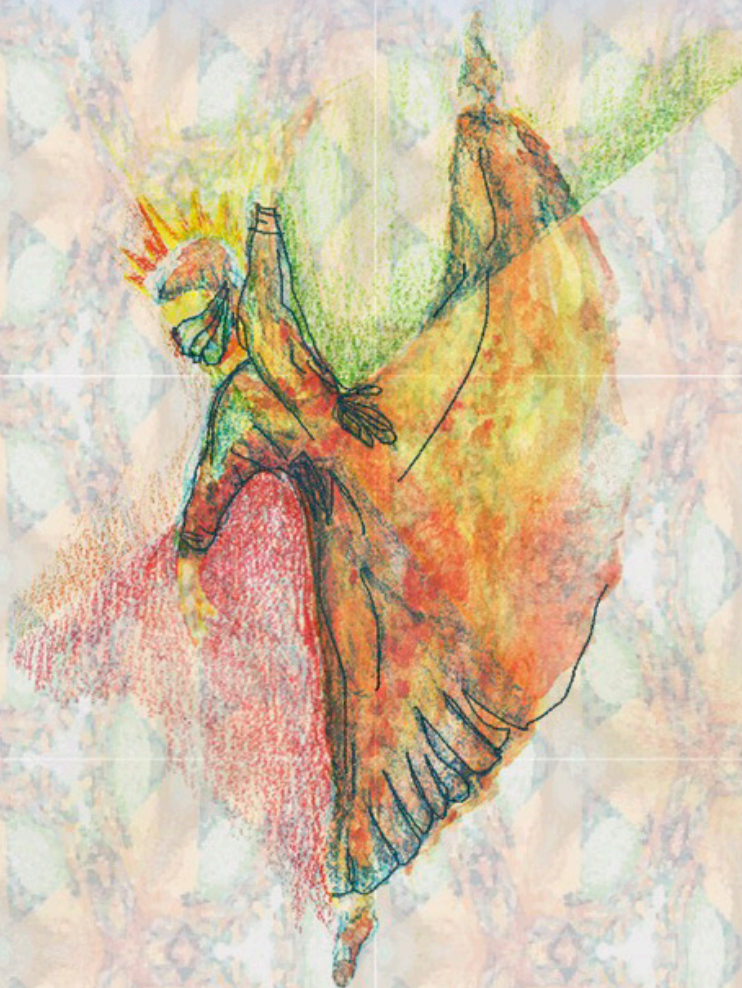
As the time drew near, our dog shifted abruptly from his dog bed into a spot below dad’s bed, directly under his

heart. The Parkinson's shake he had for over a decade in one hand just disappeared. Around midnight on Friday into Saturday my brother snored loudly, as the dog snored in a synchronized echo. I was trying to listen to dad's breath. I checked the horrible virus news on my phone for just one minute or less, thus momentarily stopping my listening. When I turned my attention back, I felt his heart and knew. He took his moment to depart without all that embarrassing excessive love talk.

Sadly, I can try to forewarn other families to protect against more than just infection when you consider the consequences of COVID-19. But my cautionary tale boils down to advising a vigilance that may be useless. At this point, if some staff in health care facilities continue to refuse vaccination, as is the case in every state, I do not know what actions can prevent the collateral damage from COVID outbreaks in nursing homes and hospitals across the world. I know I could not have taken my dad into my home across state lines during the COVID crisis, and would not have been strong enough to transfer him several times a day. There is a parallel staffing crisis amongst home health workers. And I have since heard stories from others who have told me things like: "After COVID, there was not enough staff left to keep turning my great-uncle so he died from bed-sores." What am I left to say to my readers here? "Brace yourself...it will be so terribly sad."

We will simply never know why my dad declined so quickly. Did he hit his head in addition to what turned out to be a fractured hip? Did he bleed internally? Was it the horrible shock that somehow put him into a rapid decline? The investigation of his unattended fall was simply more meaningless paperwork. I keep coming back to the expression, "Everybody is guilty, but nobody's to blame." My father's death was not from COVID. But he was one more casualty of the COVID cascade of tragic consequences. ▀

Dr. Meldrum is an associate professor of psychology and director of the program in health and industry at Bentley University in Waltham, Massachusetts. This essay was originally published in Hektoen International.



FLOATING

Alicia Weaver, MA

Alicia Weaver is a three- (soon to be four) time Florida State University alumna and military brat. She loves photography, reading, coffee, and her black cats.



At the Peak

Marielys Figueroa-Sierra, MD

At the Peak, I hear the water, all the leaves and majesties,
It is clear, the sound of nature, it is of the greatest ease.

It is full and loud of silence, as the air and clouds collide,
It reminds me of my passion, as I walked the path a bride.

It removes me from the sadness, of the dying and the dead,
and it clears my mind to empty, as I know what lies ahead.

It is like a quiet painting that your mind, the canvas, draws,
all the beauty and its stillness, has the self-neglect at pause.

It reminds you of your struggles, and informs you to let go—
all the rocks placed on your path are only there to make you grow.

The air you breath, it makes you stronger, but reminds you that you're weak,
It only takes one step to fall, to fall from silence at the peak.

Dr. Figueroa-Sierra graduated from the College of Medicine in 2016 and is a rheumatologist currently practicing in Naples, Florida.

A Night Routine

Michele Troutman

There isn't a loss I've encountered that I haven't buried
In between my mother's legs
She swats a paddled brush
Against the backside of my hand
Gentle reminder of limitations
Even when the grasp feels too tight
Movement ruins aesthetics
She cradles each strand of coil
Lay each of my baby hairs to rest
With precision finds a place
For each helix until she satisfies
Herself admiring the chandelier
Light shed across two dark imprints
Of shadows that once saw grace
Now hollowed seeking whispers of comfort

Michele Troutman is a Maryland native living in Boston. She is a lover of science, coffee, fundamental rights and her stout cat Brady.

THE LONG WAY HOME

Emily Gansert
Class of 2024

BARE

Pam Anderson



Neon Green was the color I wore as I “may-I-take-your-order”-ed my way through my first job at McDonalds. Certainly not awful: bright, cheery, All-American. But for me, it was a tragic color, incapable of masking underarm sweat stains. At age 16, I spent most of my time at work with my elbows pressed tightly at my sides so as not to shock or alarm the next customer, but each night as my shift unfolded, the sweat circles spread to a monstrous size. One survival mechanism was to frequently offer to stock the frozen goods, so I could spend some time in the walk-in freezer.

Brown was the color of the leather shoes I was wearing in chemistry class one day when a classmate inspected my feet and asked if it were raining outside. I shrugged my shoulders not understanding, and then she pointed and said, “Your shoes. They’re soaked.” I wasn’t quick enough at the time to retort with something clever, so I simply replied, “Sometimes I sweat through them.” We both laughed then: she, because it sounded absurd, and me, because I surprised myself with my honesty.

Violet was the color of my prom dress. Because I was on Prom Court, I had to waltz with my date after the “Grand March.” Thankfully, in 1980 the prom trend was wearing gloves with our long dresses so I didn’t have to worry much about my hands sweating as we danced. However, to combat other possibilities, I spent the day of prom sitting in a steam room at the health club for as long as I could stand it, trying to eliminate every extra drop of water from my body so I wouldn’t worry about sweating through my gown.

Caramel was the color of my Howard Johnson’s waitressing uniform. I spent my first summer during college serving pancake and egg breakfasts, and I was often busy enough that I didn’t persevere on sweating the way I had in high school. Until, that is, one morning a customer asked if someone had run into me with a pitcher of water. I rushed to the bathroom and stared, momentarily paralyzed. The entire back of my polyester dress was soaked through,

shoulder blades to waistline. From then on, after every tour of the dining room, I’d stop in the restroom and angle myself under the hand dryer to blow my uniform dry.

Lavender was the color of my bridesmaid dress. I’d recently discovered garment “shields” that were meant to prevent underarm stains, so I’d gone to a seamstress and asked her to sew shields everywhere in the lining of my dress. It was a good plan, but the dress had an open back that revealed sweat streaming down to my waist as we stood facing the altar throughout my friend’s ceremony. After the wedding, a woman I hadn’t met came up to me and whispered that I had “sprung a leak,” assuming, I suppose, that I didn’t know.

White was the color of the pantyhose I wore one day while teaching high school. I was standing in homeroom distributing materials, when almost out of nowhere rivers of sweat started rolling down my legs. The bored students one by one became interested in what was happening at the front of the room. I tried nonchalantly to assess the damage; pantyhose sopping, it looked as if I had wet myself. I made a quick excuse and fled to the restroom to blot my legs with coarse brown paper toweling. I prayed no one else would enter and witness this private and humbling act.

While it may seem trivial to some, my hyperhidrosis—excessive, uncontrolled sweating—has been the challenge of my life. When I speak of my neurological condition—and I don’t do it often—well-intended people often respond with statements like, “Oh, I get it, I sweat like crazy, too,” and I want to scream. Most people will never know what it is like to have to consider any event or new circumstance for escape routes to cool off or privately wipe down body parts, or to create strategies to hide or distract others from noticing sweat. Every article of clothing must be considered for the “sweat factor,” and every plan must have a contingency.

Many years ago, I was at a wedding and danced with my dad. My palms began to sweat, and I tried to pull my

hand away from his. "Pam, it doesn't matter to me," my dad assured, but it mattered to me. Even though I cannot control it, this condition has created a deep sense of shame. It took me years to go to bed with my first husband without my socks on.

To add insult to injury, both of my children have inherited this crazy condition. One day when my kids were young, my daughter walked between me and my son and grabbed our hands, asking to be swung. My son pulled his hand away, telling her she wouldn't want to hold his sweaty hand. It broke my heart, but I feigned indifference. "It's only water, honey, who cares?" But, of course, it mattered to him.

I wish I could champion the concept of loving ourselves despite our imperfections, but I'm still working to get there. I accept a lot about myself that I have no control over, but this...this I simply endure. I still have cringeworthy moments (like at a recent wedding where someone who should know better proclaimed in front of other guests that she had noticed the beads of sweat forming on my back in the hot church), but perhaps it's noteworthy that I can laugh about it more, cry about it less. Perhaps it's progress that I have developed a "system" I can work within, and that I'm more vocal about what I need ("Can someone turn a fan on? I'm boiling over here!"). Perhaps it's important that I can talk frankly about my condition with those I trust, and that I can share strategies with others who share this condition. Maybe, as its one positive, hyperhidrosis has given me a tremendous amount of compassion for others dealing with their own private challenges, even if, to me, those challenges don't always seem "that bad."

One night, a few years before we were married, my current husband and I were watching a movie together in bed. Our legs were entwined when I felt my feet begin to sweat, so I moved to pull away. Parker, a former wrestler, trapped my feet between his legs and wouldn't let go. I half-laughed, half-cried as I asked him to release me; it's embarrassing, I told him.

"See, the thing is," he told me, "you don't have to be embarrassed. I don't give a damn." So, with my sweaty feet caught in a scissors hold between his legs, knowing that I would always remember this particular moment of

insistence as something new and important, we continued watching our movie.

I'm not sure what's next for me as I stumble along the path of self-acceptance, but I do know one thing: no matter what color clothing I wear or how much my hyperhidrosis plagues me, at the end of each day as I lie next to my husband in bed, I will not be wearing socks. ▪

**"PERHAPS
IT'S IMPORTANT
THAT I CAN TALK
FRANKLY ABOUT MY
CONDITION WITH
THOSE I TRUST,
AND THAT I
CAN SHARE
STRATEGIES
WITH
OTHERS
WHO
SHARE THIS
CONDITION."**

After 30 years as a high school English teacher, Pam Anderson retired and decided to dedicate energy to her own writing and completing her MFA in creative nonfiction at Sierra Nevada University. Her essays, interviews, and criticisms have appeared in Manifest-Station, Bookends Review, Sierra Nevada Review, and Chicago Review of Books.

Sunrise at Albert Einstein College of Medicine

Miguel Rodriguez, MD

*As the warm morning blend of colors quietly creep
through your window, you take a breath
to stare and then head out to catch a plane—
the sun rises at Einstein today.*

*Well, I guess it rises everyday,
but the feeling of new birth,
of light out of the darkness,
inspires me Today.*

*The sun rises at Einstein today
as new baby doctors are born
and ready to learn.*

*The sun rises at Einstein today
as re-energized medical children finally go out to play,
their Neuro test behind them,
and a couple days of recess ahead.*

*The sun rises at Einstein today
as the medical family remembers
an empty seat, to be filled with strength,
love, learning, and re-birth.*

*The sun rises at Einstein today,
and yes, it rises everyday,
but it feels especially lifting today.*

Miguel Rodriguez is a family medicine resident at Loma Linda Medical Center. He woke up to beautiful sunrises at the Albert Einstein College of Medicine for five years. This poem encapsulates the loss and growth, the re-birth and persistence, the small things that push us forward as we begin our medical journey.

INVISIBILITY AND IDENTITY OF PHYSICIANS AMIDST THE COVID-19 PANDEMIC

Kavita Krishnan

Kavita Krishnan is a third-year medical student at Loyola University Stritch School of Medicine. In her free time, she loves working on art and combines her love for music and medicine through a group called Healing Notes, which performs songs for pediatric patients in the hospital.



All It Takes Is a *Smile*

Justin Kuhlman, MD

I walked into my preceptor's office on the first day of a new clinical rotation with hospice and found a bright face beaming ear to ear. A smile. That's often all it takes. "Look at that quote on the wall because that's the heart of what we do here," he immediately said to me. Turning around towards the plaque on his wall, I read the quote aloud, "I alone cannot change the world, but I can cast a stone across waters to create many ripples." Quickly reflecting on the phrase, I honestly found it cliché at first glance...until I read who had said it. Mother Teresa of Calcutta. I knew that name – I had studied her growing up. I always admired the five-foot-nothing nun who possessed the most deformed feet, and who throughout the world had opened numerous AIDS clinics, homes for the dying, and orphanages for unwanted children. I always wondered how someone so tiny, and seemingly unappealing, could do something so incredible for so many people throughout her life? How could someone so ordinary do something so extraordinary?

Before we had the chance to talk more about the quote, my preceptor instructed me to hop in his car and we drove to a nursing home. He said this wasn't a formal part of the rotation, but I figured he would explain more about patient management in nursing homes or something along those lines. That was not the case. Upon entering the nursing home, my preceptor seemed oddly excited. It's a nursing home, I thought. What could possibly be so exciting about a nursing home? Making our way through the hallways, it was no different from any other nursing home I had visited. Half of the patients were resting in their rooms while the other half were either creeping through the hallways with their wheel-chair bound feet or simply catching repose against a wall or chair.

As we passed through the halls, multiple nurses and employees joyfully greeted my preceptor. It was apparent that he was well liked by all of the nursing home staff. Meanwhile, I was still wondering what in the world we were doing here. We continued our stroll through the common area where some residents were sitting idle and others were watching TV. What were we doing? I

was still clueless. Finally, we started making our way back towards the front. What was the point of that, I thought. Despite my relief in seeing the exit doors ahead of us, I suddenly noticed something unusual before we left. Every single patient we passed by on our way out of the nursing home had a smile on their face. Why were they smiling? For a few seconds, I couldn't figure it out. Then, I caught sight of it. It was not until I glanced over at my preceptor when I noticed that he was the initiator of the exchanging smiles. Without saying a word, he would smile and nod as he passed each resident, and they would light up in return. Then, we left the nursing home.

Getting back into his car, my preceptor explained to me that he tried to visit residents in the nursing home as often as possible. Why? We didn't even truly visit with any of them, I thought. He then stressed the importance of having compassion for every person I would encounter as a physician, regardless of their circumstances and background. Even if a person wasn't my patient, he urged me to treat each individual with dignity, respect, and empathy. Everyone is going through a trial in life in some capacity or another, especially in medicine. As he spoke these words, I became greatly inspired, particularly because this man was not even a physician. Truth be told, he was only playing a small part in the midst of a large interdisciplinary hospice team. He went on, "Do you know where the root meaning of the word 'compassion' comes from?" Seeing the stupefied look on my face, he answered his own question, "It means to suffer with the person." When I heard those words, something clicked inside my head. I reflected on the smiles of the nursing home residents, and began to understand why we visited the nursing home that day. We were not visiting the nursing home. We were not even visiting patients. We were visiting each and every person.

I imagine that each medical professional cherishes the thought of saving countless lives by means of our medical expertise (rightly so). However, at the heart of it all, that seemingly purposeless stroll through that very normal



DENTAL HYGIENE
Chaitali Hambire, MDS

nursing home taught me that in order to save lives, we must first walk with them, and dare I say, suffer with them. Through something as ordinary as a smile, my preceptor taught me that as future physicians we have a responsibility to enter into the lives of our patients through ordinary words and actions. This is accomplished not necessarily by extraordinary acts, but by actions as ordinary as a smile. "I alone cannot change the world, but I can cast a stone across waters to create many ripples." The disposition that motivated Mother Teresa of Calcutta allowed her to accomplish great things not by doing prestigious acts, but by doing small things with great love. Perhaps that is why someone as ordinary as Mother Teresa could do something as extraordinary as she did. As soon as I made this realization, I immediately felt the desire to express my gratitude to my preceptor for teaching me such a profound lesson, but before I had the chance, we had reached my car and he told me that we were finished for the day. I briefly thanked him, got out of his car and shut the door behind me, when I glanced back in his direction one final time. There it was again. A smile. That's often all it takes. ▀

THE 6TH ANNUAL "HUMANISM IN MEDICINE" ESSAY CONTEST

*Sponsored by the Florida State University
College of Medicine Chapman Chapter
of the Gold Humanism Honor Society, in
partnership with HEAL: Humanism Evolving
through Arts and Literature.*

Justin, or "JJ," is a proud graduate of the class of 2020 and is now a second year internal medicine resident at the Mayo Clinic in Jacksonville, Florida. After residency training, he plans to pursue a hematology/oncology fellowship where he hopes to care for and walk with those battling cancer.

| NOVEMBER 30TH, 2019 |

Katherine Foley, MD

It was the Saturday evening after Thanksgiving, and I was returning to my regional campus from being at home with my family for the holiday. One minute I was driving on a familiar interstate, a drive I'd made what seems like a million times before, and the next I was watching a small SUV flip over the hood of my car. Everything after that happened so quickly, yet I remember it all in excruciating detail. My car spinning from hitting the brakes so hard. Running across two lanes of interstate traffic trying to get my 911 call to go through. Pulling a screaming six-year-old through the broken shards of a car window as someone yelled for a fire extinguisher.

Just several weeks prior, I had witnessed a man on a bicycle get hit by a car. I pulled over, as had a paramedic and an intensive care nurse. I remember the feeling of relief as these two people took charge, knowing that I would have had no idea what to do in a situation like this had I been the only medically trained individual around. As a third year medical student, I thought, I should be able to do something here. But I hadn't really had to, and I was so grateful the others were there.

But that night in the pitch black in the middle of nowhere on the interstate median, I looked up at the half a dozen bystanders who had pulled over and asked if anyone was in the medical field. The resounding silence and wide-eyed looks of horror answered the question for me without anyone having to utter the word, "No." It was just me. I asked a teenager to hold a towel to a bleeding head, had another person try to calm a man with a clearly broken femur and keep him from moving. And I knelt there on the muddy ground with two fingers on a woman's neck, desperately trying to find the pulse that I had just located two minutes prior. I never found it.

The first responders got there and I was all but shoved out of the way. I stood there covered in dirt and blood, watching them, completely on my own and still trying to process what had just transpired. The ambulance left, a helicopter came and went. The bystanders had gone by now.

At some point I dropped to my knees and felt a warmth around my shoulders. A woman had her arms around me. It was the woman who had been driving the car behind me, returning with her family to the same place I was going. We had crossed the interstate together. She asked me my name. She said, "I'm just going to sit here with you for a few minutes. I think someone needs to sit here and be with you. So I'm going to be with you here." I said nothing to her, just nodded.

I will never forget that moment for my entire life. I had just witnessed one of the worst things any human being could witness. Up until this point in my medical career I had seen one person die, a 100-year old woman in the hospital who was DNR, and I happened to be in the hallway when the Code Blue was called. As cold as it may sound, I hadn't lost a wink of sleep over it. This night, November 30th, 2019, I had shone a flashlight into a human's eyes and watched the life literally disappear from them. This woman sitting with me now sensed the gravity of that. As everyone moved in a giant blur around us, this woman saw that I needed comfort.

Her arms around me kept me grounded and safe. The compassion she showed me that night is something that has yet to be matched in any moment of my medical career. As medical providers, I think we often forget about the invisible impact of what our patients and their families go through. I didn't have a physical scratch on me, but the impact of that night and that woman's actions will forever remain in my mind. It showed me the importance of looking out for the unseen wounds. Our patients' families who are dealing with a diagnosis in their own silent ways, an exhausted caregiver's well-being, the long-lasting consequences for those around our patients who are not technically ours to care for. Even our colleagues who have had to endure difficult situations or see terrible things and continue working as if it were any other normal day for them. These are aspects of medical care that are constantly right in front of our faces but are never supposed to be the center of our attention.

As a future surgeon, I hope to apply this compassionate care to the family members of my patients. Support systems are an important part of healing, but they may need their own support sometimes, as do our colleagues who deal with illness and death. Those without physical ailments need our attention, too. And it's the small efforts—the extra five minutes we may spend calming a mother's nerves before her child goes into surgery, the extra effort it takes to discuss a trauma victim's nightmares that sets us apart.

During the first week of my third year, my surgery mentor told me that a simple, “We care about you,” directed to your patients and their families is so much more impactful than one might assume. She told me studies have shown that simply speaking those words out loud can lessen anxiety and build trust between patients, families, and their doctors. Although that night everyone else around me needed more attention than I did, this woman saw my silent pain and her, “I care about you,” resounds with me for a lifetime. I am determined to play that role as I treat my patients and care for their families. ▪

Dr. Foley graduated from the College of Medicine in 2021 and is currently a resident in general surgery at the Louisiana State University Health Science Center.

THE INTIMACY OF CONNECTION

Anabelle Rosenthal
Class of 2024



Jane Doe & The Resident

Michael Tandlich, MD

Jane Doe was a middle-aged female recently diagnosed with masses in her pelvis and lungs, highly concerning for malignancy, and she was pissed. She wanted to leave. She had won a free cruise and it set sail in two days.

"Ok," said my attending. As Jane carried on, he walked away. "We'll come back, Miss Doe."

A moment later and my attending physician already was seeing the next patient. We had many, and there was no time to waste. We rounded the halls, stopping in front of each patient room to form a large circle of healthcare workers and discuss updates in each patient's case. It was a long process, and my mind was drifting. Jane's reaction had struck me. If Jane needed immediate evaluation and treatment, how could she want simply to leave?

I wanted to know more.

Turns out, so did the resident with whom I was working. Maybe an hour after seeing Jane, while my attending was speaking, he leaned over. "Hey," he whispered, "After shift, we're going to talk to room 714." After shift, it would start to get dark outside. Surely, we would be hungry and tired, but I was pleased to stay.

As planned, we ended shift and walked to Jane's room.

For the next 45 minutes, the resident built a rapport. With compassion and an open mind, the resident intended to learn more about Jane, her enjoyments, her fears, and her motivations. Every response he gave was

in an attempt to show he was listening and curious to learn more. Every response was to show this was not about him. It was about Jane.

As Jane became more comfortable, the resident started to learn much more than one could appreciate from only a fifteen-minute clinical encounter. He learned Jane was terribly afraid. She was a mother of two daughters and could not bear the idea of dying and leaving them behind. She had a father who died of cancer and could not accept she would have the same fate. Jane attributed many of the successes in her life to a "You Can't Stop Me" attitude, and found it difficult to be told she must stay in the hospital. She was a stubborn free spirit and being stuck inside her hospital room made her feel "dead inside."

Learning Jane's experience was humbling and stirred compassion within the resident. He felt Jane's fear of dying. He felt her resentment for feeling trapped. "Ms. Doe," he said. Although tearful, Jane looked to him with an open mind. She knew well from his interview that the resident was concerned only in her best interest. She knew he only wanted to help. "I understand you are afraid," he said. He validated her experience. Then, he addressed her fears and concerns.

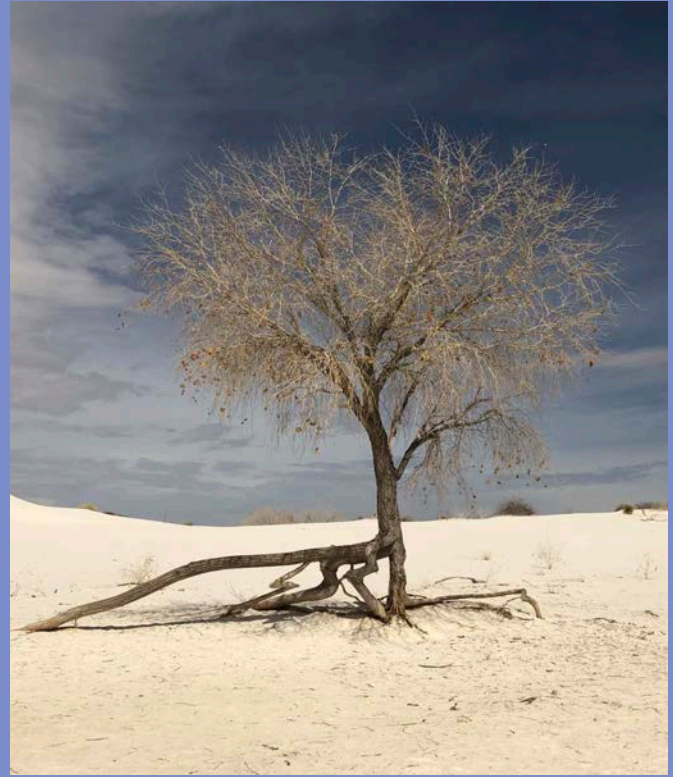
This difficult and delicate conversation was a success. It was possible only because the resident had learned enough about Jane's complexity to be able to get through to her, to "speak her language," and to make her feel cared for and understood. The next morning, he communicated his impression of Jane with her nursing staff and attending physician. As a team, they were able to further address her concerns.



TINY WONDER

Emily Gansert
Class of 2024

Emily Gansert is a first-generation college graduate and medical student who grew up in New Smyrna Beach, Florida. She enjoys traveling, photography, cooking and spending time outdoors when she is not studying.



STANDING IN SOLITUDE

White Sands National Park, New Mexico
Christie Alexander, MD
Department of Family Medicine and Rural Health

Dr. Alexander is an associate professor in the Department of Family Medicine and Rural Health and spent 2021-2022 serving as the director of the Marfa Country Clinic in Marfa, Texas.

Jane decided to stay in the hospital, and she began to improve. The next weekend, she received radiation treatment. She did not have health insurance, and while leaving against medical advice would have made follow-up outpatient treatment much more difficult, remaining in the hospital gave her the opportunity to receive financial assistance. She received the appropriate follow up care. Outside the hospital, she was able to continue seeing a physician.

Jane Doe left the hospital, sadly to return only one month later. On a different clerkship, I received the news via text message from the previous resident with whom I worked. Did I have time to stop by and visit her?

Of course I had time, the resident taught me. Of course I would stop by, say hello, show her support and show her compassion. Of course, such a visit was not required, but of course, it would make me a better physician in the end.

After my rotation with the resident, I stopped simply fulfilling my student requirements and started truly to embrace my role as a physician-in-training. "Just my next shift" at the hospital became "one of my unlimited opportunities." Each shift is a chance to serve. Each shift is a chance to make a difference. To sit at the bedside and show compassion or to spend extra time explaining and answering questions about a diagnosis became the kind of opportunities I seek out and can fulfill. Each shift is a chance to strive for excellence, and because of the resident, and because there will be endless Jane Doe's, I now strive every day to become the best version of my future physician-self. ▪

Dr. Tandlich, Class of 2020, is a second year resident in emergency medicine at Northwestern University.

BEFORE I Could Talk

Leah Eburne, Class of 2022

"Before I could talk, I used to have simple dreams. Now that I can talk, I have only nightmares."

Joann Sfar said it best in his comic series, *The Rabbi's Cat*. The titular character, a literal rabbi's cat, is a small thing, both snarky and painfully curious. I relate. And, so, as an MS3 having stumbled through the national response to the Black Lives Matter movement, the reactionary resurgence of white supremacy, and the healthcare disparities made evident by the ongoing pandemic, those words follow me.

"Now that I can talk, I have only nightmares."

How desperately, at first, did I wish not to know what people thought about me, about people of color. How carefully did I wish to protect any semblance of normalcy as the landscape of racial tensions shifted both nationally and in the medical communities I found myself in. A furtive tilt of the head to catch a nurse wearing a Blue Lives Matter pin, Fox News on in a doctor's lounge—blaring its own spin on the January 6th riots to silence, or the patient wearing his MAGA hat, then removing it when our eyes met.

Ethics assignments used to be easy fun, but became less so as the content resembled a magnifying glass swiveling in my direction. The conceit of these assignments is they can readily devolve into a checked box. Reading essays about someone's pain and frustration can feel "safe." Perhaps because they are ubiquitously digestible and leave one feeling as if they have accomplished something significant in its passive consumption. But that's the rub, isn't it?

Many of us who chose medicine have spent years learning to avoid mistakes. To find oneself on the wrong side of history, mired in bias, is to be painted forever with the mark of failure. And, as I continue to fall forward through the much-hyped 3rd year of school, we are taught to become comfortable with being uncomfortable.

We can acknowledge this field's numerous "silent curriculums" and categorize them as impersonal cultural symptoms of an inherently unequal (unequivocal?) system, and that may even afford us some room to breathe a relieved sigh.

"It's not me. I'm a good person. It's the system. We live in a society," you say. The "Live, Laugh, Love" Target placard on your desk offers its Made In China affirmation. "It's not personal."

It is personal. I know it is for me. I am hurt before I realize it happened and, suddenly, ashamed to feel anything at all. It may be that way for many of you out there as well.

While I smile and nod and tilt my head at the right empathetic beats in a conversation with a white patient crossing his legs over a telltale black lightning bolt tattoo. While an attending hones the well-beloved craft of speaking out of both sides of his mouth—caramelized language with an empowered authority figure and cool, staccato questions for his lucid Baker Act. While we think about vulnerable loved ones in the midst of a pandemic, in the midst of law enforcement militarization, in the midst of a resurgence of the none-too-code normalization of "good ol' boy" white supremacy, etc. etc. etc. The amount of emotional distress, at first, bordered on parody. It's not okay. But learning to be "not okay" is, well, okay.

And I prefer the nightmares, because I can talk. I will be a physician. The simple dreams are gone.

Many of us have not been raised to understand how to grow. And that is why ethics discussions (see, I wasn't coming for them), cultural sensitivity seminars and resources, curriculum-mediated group discussions, and the like will continue to have value although they can seem trite in a field, such as ours, that has spent years convincing itself physicians suffer if they empathize. I wished to holy hell that what I felt could be undone but I am a different person on the other side of this. It is too late and I must keep moving forward. New horizons are ahead.

I – we all – need to continue to accept that our pain and our frustration, as well as that of vulnerable people in our lives, is personal. And that when we are wrong, it very well may be personal. And that is okay. The point of reflection is growth. Growing can be painful, but flinching from it won't undo what I've seen and heard and done. What I felt. What we felt. As long as we continue to normalize and encourage personal development, making mistakes, acceptance, and accountability, then we can save our field. Perhaps, we can save ourselves, too. ▪



BLACK BEAUTY

Ramiz Kseri, MD

Department of Clinical Sciences

Dr. Kseri is a board-certified internist and pediatrician with a passion for portrait drawing. Black Beauty is part of his "black excellence" series; other portraits in this series can be seen on Instagram @Centricity_art.

THE 7TH ANNUAL “HUMANISM IN MEDICINE” ESSAY CONTEST

*Sponsored by the Florida State
University College of Medicine
Chapman Chapter of the Gold
Humanism Honor Society, in
partnership with HEAL: Humanism
Evolving through Arts and Literature.*

ROADMAP to RESILIENCE

Abigail Schirmer, Class of 2022

Some days change your life forever.

Mine changed one day in a Hematology & Oncology clinic. I bolted out of the Clinical Learning Center to make it on time. You see, we don't learn about Heme/Onc until the end of our second year of medical school, so my first-year self was hopeful to learn something new today.

As I pulled up to the building, I noticed individuals of all ages, races, abilities. One woman clung to her companion with one arm and to her oxygen with the other. One man slowly wheeled himself up to the sliding doors lined with signs of encouragement—signs which were definitely needed.

I made my way into the waiting room, which could have easily been mistaken for a war zone, with warriors of unthinkable battles lining the seats—unshaken by their circumstance.

“I'm not strong enough to be here,” I thought to myself, taking a deep breath. Through a single door, I made my way to the clinical rooms.

Only one appointment this afternoon. A new patient with a series of acronyms and question marks by her name. “A zebra?” I thought to myself, admittedly getting a little excited. We talk about rare conditions in school, but hardly ever see them. This patient was my age, the picture of health outwardly, but internally it seemed something had run awry and no physician could figure it out.

The hematologist greeted her and her mother. She established rapport and built a foundation of trust effortlessly. She communicated compassion as if it were her second language; something I had yet to witness anyone ever do.

Her tone slowly began to shift as her hand reached for another. The air escaped the room—the bad news. We all felt it. The silence was deafening.

Somehow this news began to embody hope amongst uncertainty. As this hematologist empathized and affirmed the patient's fears, doubt melted to optimism in the face of so many unknowns. She depicted a bone marrow biopsy as a tool to rule out the worst things, rather than rule in the bad. She became a beacon of reassurance to a patient who was terrified that her life, much less her future, was lost.

"You are so strong," she empowered.

"Yes, I am," I agreed, tearfully.

In a moment like this, resilience was my only option. I thought I was going to lose everything, so staying the course to hopefully prevent that was what I resorted to. Amongst my death grip on what I once knew, I discovered salience in what my purpose really was: becoming the best, most humanistic physician I can be, just like my hematologist.

I suppose there were other roads that I could have taken to earn resilience, but they were not options for me. This road chose me, there was no detour or exit sign. I couldn't give up the fight for my health. I couldn't give up the path forward to one day caring for my own patients with the same compassion that I received.

The resilience I have learned through overcoming this obstacle will help me overcome any future challenge I may face in medical school, as well as future surgical training.

But this is not what will make me a better physician for my patients.

The way I was cared for significantly impacts how I will care for others. I will be better at listening, because I was listened to. I will be better at communicating compassion, because it has been effectively communicated to me. I will know how to empower my future patients to recognize their strength, because I was empowered to recognize mine, despite feeling as if my future was evaporating before me.

I hope no one experiences what I did, in any capacity or at any phase of life. My experience was not a choice, it was a reality in which I made the conscious choice to transform a circumstance into a strength to use for the care of others.

I was extended grace beyond all understanding. I was supported from every measurable angle.

Eternal gratitude and resilience are what replaced fear and death's grip on what my life once was, focused to serve what it will be.

You see, I now possess a roadmap to help others navigate the unpaved paths of carrying the weight of illness. Not all of these roads include the same destination. Not all the potholes or inclines are the same size. But anyone who has traveled distance on this road understands the fear and significance of the journey—a journey that I have had the blessing to stand on both sides of as a patient, and one day, a physician. "



HIDDEN LILY

Paula Kreutzer, MD

Dr. Kreutzer graduated from the College of Medicine in 2021 and is currently a resident in emergency medicine at UF Health.

I was on call over the weekend. It was a Saturday and I really did not want to be at the hospital. We were just decompressing from a case when my attending got consulted from the emergency department (ED) for what seemed to be a spinal tumor. He pulled up the patient's chart and MRI showing a large mass occupying her spine. He said, "Looks like a schwannoma." And then we read the radiology report which read, "Most likely a schwannoma or meningioma, but possibly a plasmacytoma because of multiple myeloma disease status."

We went down to the ED to meet and examine her. Six months later I can still remember the pink Yankees hat, blue jeans, converse sneakers, and the smile she wore that day. Some patient encounters go smoothly. The patient is friendly and easily offers a history. Others are bumpy. The patient does not easily offer up information and requires redirection and detailed questioning to get answers. This particular encounter was smooth sailing.

I was introduced as a student working with the physician and she replied, "That's great, always good to see people learning, and we need good future doctors." We began talking with her about the symptoms that brought her into the hospital and her history of multiple myeloma. She explained that she had been receiving specialized chemotherapy at the Mayo Clinic from her dedicated hematologist/oncologist for some time, and that it appeared everything was good and controlled from her most recent scan. She detailed the large number of doctors and specialists she had seen since her diagnosis, as well as the struggles she went through to get enrolled in a clinical trial. Through all of this she did not seem angry or upset by what she'd already been through, more just exhausted, like the disease was slowly wearing down her energy and will to live.

We explained that she had a mass in her spinal cord

What Do PATIENTS Give Us?

Jamieson Glasser, Class of 2022

which required removal. In that moment I did not really understand the severity of what was transpiring to truly appreciate her reaction. Upon reflection, I am amazed at how calm and stoic she was in the face of even more adversity. I wouldn't realize it until later, but she had made a decision to respond to her adversity with a certain elegance. I also remember after meeting with the patient pre-operation, my attending said, "It's going to be something bad and rare. She's so nice. Bad, weird stuff always happens to the nice people."

The operation went well, but the tumor did turn out to be a bad tumor suggesting a grim prognosis. Positively, though, she was pain and symptom free, meaning our efforts weren't for naught.

Then I got to thinking about the quote, "Bad stuff always happens to nice people." Was she so nice because of everything she'd been through? Did she see her aches and pains and suffering through a different lens than the average person might? Maybe going through a tough disease or diagnosis leads a person to not take any day or any encounter for granted. She easily could have been nasty and surly with us, but she was not.

The other end of the spectrum is the idea that "bad things happen to bad people," which some people believe is karma for their "badness." The truth is nobody deserves to have anything bad happen to them. However, if the person has been less than an ideal citizen, society tends to view their demise as less of a tragedy.

Reflecting on all of this I was reminded of a quote I once read from the six-year-old son of a veterinarian: "People are born so that they can learn how to live a good life — like loving everybody all the time and being nice, right? Well, dogs already know how to do that, so they don't have to stay for as long as we do."

Nobody deserves or wants to die, but maybe this woman and other people who fall into the “bad stuff always happens to the nice people” category are more “ready and accepting of the idea of death” because they have a better understanding of how to live a good life and love others and not take a single day for granted. Maybe my patient had learned how to approach daily life with the mindset that our loving pets seem to master so easily.

Six months later, I found out the patient had passed away.

I thought about what I had taken away from the patient and the experience: a very interesting diagnosis and operation and a fascinating case-report. Then it dawned on me that it was much more than that. She had given me the perspective that, yes, bad things can happen to good people, but the reality is bad things happen to all kinds of people.

What is in our control is the way we choose to respond and react to “bad things” or adversity. This thoughtful woman had clearly chosen how she was going to respond, with a positive attitude and gratitude towards anyone trying to help her. I will not be able to control the bad things that happen to my future patients, but I will be able to control

the way in which I respond: calmly, confidently, and with 100% of my focus and skills.

Perspective is a gift we are given from each and every patient we encounter. If we truly empathize with them and try to see the world from their point of view, we will gain perspective and insight into their life, which in turn might give us a new found perspective and way of doing things in our own lives. The opportunity to learn from and integrate new ways of thinking to better serve our patients is right before us in every single patient that we see, we just have to be open to the possibility. ▀

THREADS ON A HEART

Karling Gravenstein, MD

Dr. Gravenstein graduated from the College of Medicine in 2021 and is currently a resident in general surgery at Memorial Health University Medical Center in Savannah, Georgia.



Coup d'état in Myanmar

June S. Gould, PhD

The rain is not visible from my apartment,
only a drizzle, not at all like the rain
in Myanmar's monsoon season.
I open my bedroom window, stick my hand out.
Rain prickles my palm.

America's attempted coup failed,
and that's a relief, if only for a while.
Burmese have not rested since their military coup.
They stay awake, are angry, listen, watch,
eat tea leaf salad, drink milky tea (as usual),
and some march with the "People's Protest
Against the Coup."

Will their demands release Aung San Suu Kyi,
will their bullets stop firing into female protestors?
If they die, or return home in despair,
will their thoughts be stuck in jail, tormented?

If they lose, when they are released or go home,
their vote betrayed, will they say,
my blouse is too loose, worms crawl in my stomach,
they took my shoes, I hate cold brown water,
or I thought they used rubber bullets.

The definition of a coup in my dictionary,
is a seizure of political power by the military
and now, the dictionary next to my bed
is under my beloved book,
"The Meaning of Everything."

In my apartment, miles away from Myanmar,
I wait for a just conclusion.
If it is not fair, my mattress will ache,
and the drizzle outside my window
will twist into a tortured tornado.

June Gould, poet and novelist, is the author of The Writer in All of Us. She has served as a writing workshop leader for the International Women's Writing Guild, and her poems have been published in The Journal of Psychohistory and other poetry journals.



THE MERGING OF FAITHS

Nida Mohyuddin
Class of 2022

The Masks We Wear

Shellon Baugh, Class of 2023

Some masks are red as crimson,
Some are white as snow,
Some are for protection,
Some are just for show.

The surgeon's mask can cover
From nasal bridge to jaw.
One-sided is the Phantom's mask
To cover up his flaw.

A nail technician uses a mask
To limit the acetone fumes.
The masks at masquerade balls
Are part of the costume.

Some masks we wear for COVID
Are not the best, we know.
Some people bought their masks online,
Some people learned to sew.

No matter where we got the mask
One thing we all do share:
A desire to protect each other,
Starting with the masks we wear.

CON

Michelle Nguyen, MD

My parents immigrated to the United States to seek political asylum after the Vietnam War. My brother and I were born and raised in San Jose, California. Growing up Vietnamese-American, I felt displaced from either world. I never spoke Vietnamese outside of my home, embarrassed that I did not know as much as my Vietnamese friends or that I would not blend in with my American friends. I tried to laugh as my friends slanted their eyes in pictures to make funny faces. I shrugged it off whenever people joked about Asians eating a myriad of animals with disgust in their voice. I felt ashamed and conflicted knowing my parents grew up in times of war and famine, going days without eating. These “strange” cuisines were not only a part of survival, but also a way of life. Nonetheless, I grew resentful of my cultural background as it served as a constant reminder that I could never be American enough.

At the beginning of the pandemic, my mother would joke about how I should take my allergy medication before going into my clinical rotation, fearing people would think I had the “China virus.” We laughed as we mocked President Trump’s labeling of the virus, thinking nobody would be ignorant enough in today’s day and age to actually believe him. Later on that week, I overheard the clinicians and patients I worked with using the same term to discuss their suspicions of bioterrorism, saying that they would rather die from the virus than receive a vaccine made from China. With each week that passed, I found myself having to suppress those feelings of shame by association more often. One of my best friends posted a meme, insinuating that it would have been better to shoot and kill the first Asian person to eat a bat to prevent the pandemic. I’ve seen several videos circulating online where Asian American communities were not only shunned, their businesses suffering from the lack of customers, but also where they were getting sprayed down by strangers with Lysol and yelled at to get off the subway as though they were the vectors of infection. They were getting spit on, coughed on and assaulted as people questioned why they wore masks and chastised them when they did not. In some places around the world, restaurants started to post signs refusing to serve Chinese customers. Still, it

TAAGION

hadn't sunk in. These incidents, while awful, happened to someone else somewhere else.

On March 31st of 2020, my brother was driving out of the parking lot of the grocery store when a Caucasian woman raced her car out in front of his, preventing him from exiting the lot. Then she aggressively reversed her car. Fortunately, he was able to move his car in time to prevent an accident. The woman got out of her car and began yelling expletives and racial slurs. To avoid further conflict, he tried to drive through another exit in the parking lot; she raced to block him off at every point. After several attempts, he was finally able to leave. She pursued him, switching lanes aggressively to catch up with him, narrowly escaping collision with nearby vehicles. He spent the next hour driving around town until he was finally able to lose her and come back home safely. It was his 28th birthday that day. I finally realized that we had much more to fear than just the virus; we had to be wary about the people in the community, what they thought of us, and what they were capable of doing.

The very next day the Huffington Post published a story about an Asian American family getting stabbed while shopping at Sam's Club. The suspect admitted to police that "he stabbed the family because he thought the family was Chinese, and infecting people with the coronavirus." Federal law enforcement officials began warning of the surge in hate crimes against Asian American communities as more than 1,000 incidents were reported within the first two weeks of April.

With the escalation of attacks on the Asian American community, my family and I found ourselves asking questions that never even crossed our minds before. We were forced to confront the fact that our appearances could put us in a dangerous situation. Should we wear sunglasses to obscure our features further? Is it safer to go to Asian supermarkets than mainstream grocery stores, or will these become easier targets to attack? Is a mask worth wearing if it instigates people by giving them the impression that we are infected?

In the war against a virus that does not discriminate, we find ourselves fighting another war against the people who do. Unlike us, the virus is fortunate that it cannot be seen by the naked eye. It is the ultimate stealthy assassin, one that can infect and kill entire communities without consequence or blame. Like petulant toddlers in a game of hide and seek, society cannot accept that its ultimate enemy is invisible; it wants a face, a body, and a name to blame.

With the immense amount of fear in the present and no clear endpoint for the future, stereotypes give people an answer, no matter how inaccurate or damaging. They give them a sense of control in a time of chaos and uncertainty that is further emboldened by the mob mentality. The stereotype of "yellow peril" has always existed, but it is now bolstered through language and propaganda as our political leaders proudly tout the term "China virus" and the media constantly depicts China as the source of the world's problems. As the boundaries of fact and fiction are blurred through misinformation that normalizes these stereotypes, our sense of humanity and compassion for each other degrades. The coronavirus is no longer the story of an epidemic from zoonotic infection. It is a story of infection that, in its most benign form, is inherent to the inferiority of Asian culture reflected by the consumption of strange, dirty cuisines or, in the most malignant form, is proof of bioterrorism. As a result, Asian Americans are not only forced to protect ourselves against the virus, but also the xenophobic tendencies that have infected the people we used to know. We are punished by society for things we have no control over and compelled to apologize for their baseless assumptions about us as people. We are no longer perceived as equal human beings, much less Americans, but rather as foreigners in our own country where being foreign elicits fear, malice, and disgust. By virtue of our existence, we are the contagion. ■

Dr. Nguyen graduated from the College of Medicine in 2021 and is currently a resident in emergency medicine at UF Health-Jacksonville.

Mourning, Made Tender by Mercy

Mary R. Finnegan

My neighbor, walking down
the street, dog on a leash, the moon

rising in a dark blue sky, edges
lit golden by the setting sun.

Three boys approach, gun,
wielded and ready, behind them,

the sun searing a line
of light into the horizon.

He'd have given his wallet
if he'd had it on him. Instead,

the trigger was pulled, the bullet
hit. All of their hearts blossomed

into a wild wilderness.
His daughter was not there,

with the sorrowful dog, with the bullet,
with her dead father. He told her

to stay in that night, though the sun
had lit a golden edge into the sky.

And I can't stop wondering: Why?
Why did he leave her at home?

And is it true that for our souls
there is no time, no ticking clock?

Only now and always, only all
that has ever happened and will?

Did my neighbor hear a call
from that eternal now?

Leave her at home. Save her.

Mary R. Finnegan is a writer and nurse living in Philadelphia. Her essays and poems have appeared in Dead Housekeeping, PILGRIM: A Journal of Catholic Experience, The American Journal of Nursing, and elsewhere.

STARDUST PAPER
Beth Appleton

For the past 30 years, Beth Appleton has worked from her studio home on the gulf coast of Florida, a place of boundless inspiration. Beth writes: "Stardust is a cut paper piece that was inspired by December's Geminid meteor shower. With it, I send out bright wishes for the new year ahead. As the shortest day of the year passed, the sky darkened just after sunset to get a view of Jupiter and Saturn align in the west, only .1 degree apart. It was a beautiful sight! Keep looking up, friends."

Things We Lost This Winter

Alexandra “Xan” C.H. Nowakowski, PhD, MPH

Department of Geriatrics / Department of Behavioral Sciences and Social Medicine

People say grief
comes in stages, as if loss
were an eternal childhood
of peeling oranges.
My hands became practiced
with the delicate laces
of surgical masks, the slick
foam of disinfectant,
the tacky perimeters
of nitrile gloves.

Cystic fibrosis means
always being prepared
for implausible scenarios—
and fear looming like long swabs
inside the throat.

My wife does better
at ignoring apprehension, finds
eternal whimsy
in little motor tasks.
She fiddles with her headphones—
a long-ago gift from my mother,
who I suppose these days
is hers as well.
She spreads their moving pieces out
onto our coffee table,
delighting at their flatness.

Look what I did, she says
beaming brightly
at the smile cracking my path
to the center of myself.
These little moments
are everything to us now.

Not hiding so much
as biding time inside a home
where fear gets left
upon the stoop.
Trauma peaks, declines
and then returns to do its worst.
Our deepest wounds
left scars we could not touch.

Dr. Nowakowski is an assistant professor in the Department of Geriatrics and the Department of Behavioral Sciences and Social Medicine.

Author’s note: This poem describes the loss of opportunity for social contact outside the home as COVID-19 began to spread in Florida—something that has caused grief for many in our community. For people with a history of trauma, like so many we serve at FSU COM, this grief has many layers. Trauma can also come from many sources, including both abusive home environments and chronic health conditions. I explore my own relationship to the grief of a narrowed social world through the lens of past losses my wife and I have coped with in healing from our respective experiences of abuse and chronicity.



UNFOLDING

Paula Kreutzer, MD

Calm

By Kevin Reyes, MD

During the COVID-19 pandemic, many people have suffered and questioned when things will go back to normal. I composed this song to remind everyone to stay calm and keep moving forward.

Visit this link bit.ly/Reyes_Calm or scan the QR code to listen.



Dr. Reyes graduated from the College of Medicine in 2021 and is currently a resident in emergency medicine at the Henry Ford Hospital Program in Detroit, Michigan.

On Becoming Your Ball Pit

Nadia Khalil, MD
University of South Florida
Morsani College of Medicine

No numbers. That was the first rule. “Easy enough. I can do that,” I thought.

You were perched at the edge of your bed, hugging your knees, chin resting in the small valley between them, staring out the window. You wore a large gray sweater, large being a relative term here, I realized. Your hair was thin, weakly befriending your jawline. Your skin was pale white with gray undertones, without much differentiation between it and your cracked lips and your eyebrows. I was acutely aware I was composing my thoughts automatically with words like “large” and “thin,” never-words for a patient like you. “Be careful,” I reminded myself.

I fought desperately against my furrowing eyebrows and squinting eyes to paint anything but a look of pity on my face. You watched me carefully, erring on the side of silence as you sized me up, meeting my efforts to establish a new relationship with almost imperceptible changes in your facial expression. “That’s okay,” I thought, “she’s deciding whether or not to trust me.” That first day, I asked only what I needed to, and steered clear of topics of food, weight, and beauty. When I examined you, I did so delicately but confidently, attempting to create the illusion that there was nothing extraordinary about your exam, my maneuvers were just routine, you were like anyone else. Still, I miscalculated where your body was when I placed my stethoscope beneath your sweater to listen to your heart sounds, like when you run your fingers through your hair after a fresh cut and overshoot the movement. When I listened to your lungs, the diaphragm of my stethoscope tilted unevenly in the narrow spaces between

your ribs. I remember feeling your body was eerily quiet, contrary to my expectation of crisp physiologic sounds given your size. Your legs, wide, weeping, and edematous, stood in stark contrast to your upper extremities, where the circumference of your arm seemed the size of my wrist. I wanted to help you.

Most days, I came by your room at least twice. You started to grin at my arrival, and I congratulated myself for making the team. I felt, in order to serve you optimally, I needed to know you and your thought-process first. With my team’s permission, I loosened the reigns of allowed conversation subjects. We spoke of our mutual objective: achieving a level of health that portended a positive trajectory for you to live the rest of your life on your own terms. We talked about how challenging it was and would continue to be, probably for a very long time, maybe forever. We braced ourselves for stagnation and regression, recognizing this anticipation would empower us to overcome and move forward again. We would do our best to identify and utilize tools that reliably worked for you. Your eyes met mine and we both giggled to mask our trepidation for the long journey ahead; after all, this would be a lot easier said than done. You had been battling this disease for twenty-four years already.

You asked me a lot of questions; some were easy to answer, and others, not so easy. Why would someone report a few leftover scraps from your dinner? Why did we have 24-hour video-surveillance? Why did you need an escort in the restroom? You told me it made you feel out-of-control and child-like. I knew what the answers were, but how could I tell you, despite our partnership, your word wasn’t good enough? I wanted to believe we were doing what was best for you; at a BMI of 11, which barely shifted in the weeks you had been here, I believed we were. Still, I felt guilty of betrayal; little did you know I was also sleuthing for evidence of hidden food, tampering of your Dobhoff tube, and manipulation of your meal schedule. Your questions made me realize just how much your mind was tormenting you. It made my stomach churn and left me unsettled.

We needed to re-center your locus of control to free you from this imprisonment. The nature of your disease precluded an easy fix and rendered any semblance of a paternalistic patient-physician relationship useless. The treatment was not just to feed you safely and increase your weight; we needed to help you help yourself. Our medical team devised a plan-of-action that excited all of us. We created a rewards-system and focused on unconditional support. That day, my senior resident and I went down to

the hospital gift shop and bought you a pen and a journal that read “she believed she could, so she did,” and we all signed it with messages of encouragement. We urged you to acknowledge your thoughts and value them by writing them down and actively dispelling anything negative whenever you could with an aggressive pen-mark or strongly-worded response. On one day, I took you outside to bask in the sun and watch the bay, identifying landmarks for you on the skyline. Another day, the hospital’s indoor-outdoor garden. Another, the piano in the waiting room on the 4th floor pavilion, where I played for you. The next week, my attending handed me a twenty-dollar bill, with which I bought you a painting set and a puzzle, and over the following days, you showed us your masterpieces. These weren’t gifts; they were earned. You were making strides towards regaining your health. These were the markings of your triumphs, the steps-forward.

But it wasn’t all rainbows and butterflies. Every time I wheeled you from your room, I grew nervous, pleading internally with passersby, willing them not to look at you, shielding you from the potential for misconstrued judgment, as I knew you were watching them closely, the same way you did me that first day. Some days, you cried and told me how ugly you felt. Even on days I felt we ended strongly, as I moved to excuse myself from your room, I would hear you, almost inaudibly, with shoulders

stooped over, eyes fixed on your feet: “Am I gaining?”

My experience with you over three weeks on my internal medicine rotation is etched into my skull. You showed me that in order to care for someone well, you need only to acknowledge the individual in the body before you, and respect the unique, complex dynamic between the person and the person’s disease. Validation, support, and empowerment are key. Caring for you allowed me to witness, and experience, true compassion.

Your disease is your tight-rope, but we are your ball pit.

Let’s keep going. ▪

Nadia Khalil finds the practice of medicine a privilege and the role of human connection in healing powerful. She enjoys journaling, cycling, board games, coffee, and all-things brain; Nadia is currently a resident in neurology at the University of South Florida in Tampa, FL.



WHOOPING CRANE DANCE

Kathleen Wilcox
Gadsden Arts Exhibition

Kathleen Wilcox is a contemporary enamel artist. Her award-winning enamel wall pieces are exhibited and sold in juried exhibitions, art museums and galleries. Her work is published in the books The Art of Enameling, 500 Enameled Objects and The Fine Art of Enameling.

WHERE DEATH DELIGHTS

Cheyenne Andrew
Class of 2024



About this painting, Cheyenne writes: "In honor of my first patient, The Artist. I always aspire to listen, to love, and to embrace the world around me, and inspire others to do the same. This painting is in remembrance of the patients that have taught me along the way."

Remedy - An Original Piano Composition

Kevin Reyes, MD

As my foundations of medicine begin to broaden, I have realized that a remedy can mean many different things to patients. For some, it is a medication. For others, it is taking the time to hear their story. To me, a remedy is when any new situation changes your life for the better. I created this composition to portray the art of medicine through music.

Visit this link or scan the QR code to listen:



Poison Pen Letter

Alexandra “Xan” C.H. Nowakowski, PhD, MPH
Department of Geriatrics/ Department of Behavioral
Sciences and Social Medicine

Violations of consent and bodily autonomy in places that are supposed to be safe cause deep harms both individually and collectively. We share a fundamental responsibility to ensure that power does not continue to get abused following known breaches of this basic trust. The costs of doing otherwise often remain hidden from view; speaking truth to power carries a price of its own. But the consequences of inaction in the face of abuse within our community are no less devastating for the forced discretion that silences our voices as survivors. Trauma informed care means little if we do not practice it proactively with one another.

Beside me the safest person
of all sleeps soundly, her soft hair
tickling as I lie awake, vigilant.
When the boys held her down
in the lonely woods, no one
heard her scream. I have been lying
for months now, wearing two masks:
one for disease and one for rage.
The second always seems to fit best.
Goodness knows
I have had practice.
Back then I covered bruises
beneath long sleeves,
bled behind closed doors,
practiced saying no
as if it might somehow matter.
Aloud, like a benediction.
Aloud, like tender praise.
Bless me. I know that I have sinned.
Something original within me
spoke too strongly, as it always seems
to do, and made me damned.
I bite that rotten apple every day,
collapsing flesh held fast against my tongue
to keep things quiet.
We choke upon desperate words of loss—
of impotence, and the deepest of intentions.
Tears that we hold back
find themselves in one another until
everything
breaks open. How many stories
died before they ever reached that file
left moldering on expensive desks?
Thirteen months is a long time
in lessons and pandemics,
in pages buried and unearthed,
in fear of retribution.
We never could afford the cost
of so much spoiled ink, and now
only poison pens remain.
I carry them against places
he touched again, years later
instantaneously
as I read the morning news.
Those same hands—
as fresh as frozen—
closed around broken
ribs that never did quite
heal, and the scars beneath that go
deeper than all of it.

miraculous recovery

Alexandra Lackey, MD
Class of 2019

During my third year of medical school, I completed a clinical rotation in surgery. I was certain that it would be horrible. I envisioned myself in the OR, getting lightheaded, passing out onto the sterile field and being yelled at by my attending physician. I worried that the medical knowledge I'd worked so hard to learn would be neglected in favor of memorizing the steps of surgical procedures. My parents, who are both physicians, warned that I'd just be holding retractors for hours.

I want to interact with my patients, I fretted, not just hover over them while they're anesthetized.

Although I tried to keep an open mind, I knew that I was destined for a miserable time. During the first week, this opinion changed only slightly. Nervously, I trailed my attending around the hospital, nearly following him into the bathroom several times when I thought he was going to see another patient. When an actual surgical procedure was about to take place, I would awkwardly scrub in, relying heavily on the nursing staff to help me put on the gown the right way. I wasn't passing out in the OR, but I certainly wasn't in love with surgery.

Then, on preoperative rounds, I met Mrs. Smith.

A frail eighty-two-year-old, she suffered from diverticulosis and recurrent urinary-tract infections. Her CT scan had revealed a colovesical fistula—an abnormal passage between the colon and the bladder. It was slated for surgical repair later that day.

She lay quietly in her hospital bed as I examined her and collected her history. Her husband sat nearby.

"Do you have any questions?" I asked her.

"I guess not," she said. Then tears welled up in her eyes.

This startled me. Surgery is scary for any patient, but I hadn't seen anyone else get this tearful.

"How are you feeling about the surgery?" I asked.

"I'm ready to get this done with, so I can begin chemotherapy," she replied.

"You have cancer?" I asked, confused.

Her tiny, frail hands reached into the bedside dresser and pulled out a large yellow envelope containing a stapled four-page document: her CT report. As she handed it to me, I gave her a box of tissues, and she dabbed at her tears while I examined the report carefully. I saw no mention of cancer.

"It's spread to my kidney!" she exclaimed with a sob. Mr. Smith began to cry, too.

"Who told you that?" I asked.

"No one told me; it says it there on the paper," she replied, a bit impatiently.

My eyes darted to the section about her kidneys. It described normal renal anatomy, except for a simple cyst—just like one that I'd been incidentally diagnosed with, years earlier.

A mental lightbulb went off.

"Mrs. Smith, do you know why you're having surgery today?" I asked.

"To take the cancer out," she said, now clearly annoyed.

"Would you mind if I sit by you on the bed?" I asked. She nodded, and I sat down beside her.



CATCH OF THE DAY

Jonathan Grisaffi
Class of 2022

"There's no indication here of a cancer diagnosis," I told her gently.

I explained how the small intestinal pouches characteristic of diverticulosis can form fistulas, and I drew a picture to illustrate. Then I went through each section of her CT report with her, emphasizing that the findings were normal, and that her renal cyst was most likely a normal variant.

I finished, "You know, years ago I had an ultrasound that showed a cyst just like yours, and I don't have cancer."

"Oh, that's wonderful!" Mrs. Smith said excitedly. "So I won't need chemotherapy after all! You know, my life has been terrible lately with worrying about this, and with these constant UTIs and kidney infections, too. I thought that I'd have to deal with those infections for the rest of my life."

She was even more elated to hear that the surgery would resolve her symptoms and get her back to living the life she'd once enjoyed.

Through tears of joy, Mr. Smith embraced her.

"I thought I was going to lose you too soon," he whispered.

I felt thrilled to have helped to change Mrs. Smith's life so much for the better—but I also felt upset to think that, at some point, a member of her care team might have simply handed her the CT report and told her that she needed surgery, without offering any further explanation.

The surgery went perfectly, and even though I only held the laparoscopic camera, I felt proud to be a part of it.

At Mrs. Smith's two-week follow-up visit, she reported that she was doing well. When she thanked me profusely

for helping her, I once more felt humbled and fortunate to be part of a profession that touches lives in such an important way.

From then on, I began including "Do you know why you're having surgery today?" in my preoperative questions. Often, as with Mrs. Smith, the patients' answers led me to offer more explanations and illustrations.

I found myself enjoying getting to know each patient before the surgery, assisting in the OR and seeing many patients' transition from suffering to health. In cases with less-than-ideal outcomes, I sensed that the patients found comfort in the relationship we'd formed, as well as in the reassurance that we were doing everything possible to help them.

As horrified as I'd once felt about surgery, I fell in love with its ability to so dramatically improve someone's life within a matter of hours. Although I lacked the surgical skills needed to contribute substantially during the actual procedures, I found that I did have the skill to communicate with patients.

Above all, I learned that what takes place in the OR is critical to a patient's recovery—but so are the words that help patients to understand what's happening to them, and what they might hope for. ■

Dr. Lackey graduated from the College of Medicine in 2019 and is currently a resident in internal medicine at AdventHealth Medical Group Family Medicine in Orlando, Florida.

Cultivating Weeds

June S. Gould, PhD

I moved to leafy Connecticut from Brooklyn, tended a shady rock garden. No idea what made a daisy sought after, a dandelion unwelcome. My husband rode a mower in circles around the grass bordered rocks.

I poured fertilizer and water on, what I later learned, was low growing chickweed, tall and spiky horseweed, large flat crab grass, deeply cut leaves of mugwort. I pampered those plants until they thrived, even flowered.

After it rained, the rocks, covered in chartreuse moss, felt velvety as fawn's ears. I didn't know if moss was respectable or inferior, so I fed it too.

In fall, the lawn grew patches of standing water. The rock garden wore a rough layer of dried stalks, long shoots and brown wrinkled leaves.

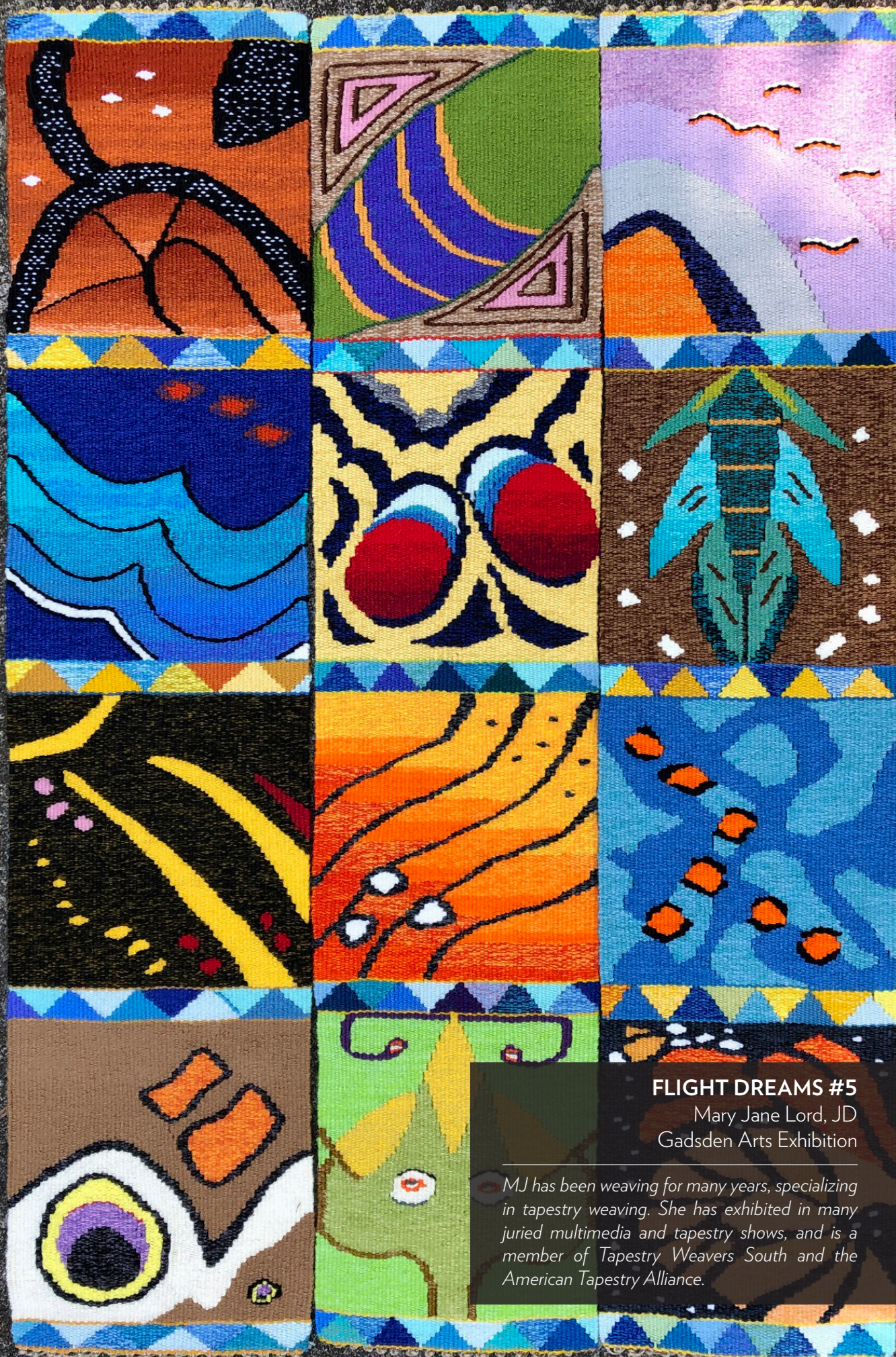
Years later, in his winter, my husband remembered the tall funny flowers. I didn't tell him they weren't flowers because, before he died, everything in the world was precious, blooming, beloved to him, even weeds.



CROCHETING THROUGH THE PANDEMIC

Tyra Brune, MD

Dr. Brune graduated from the College of Medicine in 2021 and is currently a resident in pediatrics at the University of California in San Francisco.



FLIGHT DREAMS #5

Mary Jane Lord, JD
Gadsden Arts Exhibition

MJ has been weaving for many years, specializing in tapestry weaving. She has exhibited in many juried multimedia and tapestry shows, and is a member of Tapestry Weavers South and the American Tapestry Alliance.

AL'S ALS

Sandra Meyers

"Hello, I'm Dr. Stewart," the neurologist said when he arrived. "How are we doing today?"

"Good!" says my father, perched up on the examination table. This is the special specialist the other neurologist wanted my dad to see. He has more experience with ALS. The first neurologist we saw thought my dad's initial diagnosis of stroke was wrong and that he may have Lou Gehrig's disease: Amyotrophic lateral sclerosis—ALS. Ironically my father's name is Al, so if that doctor is right, it would be Al's disease.

The doctor had looked through my dad's chart and conferred with the other neurologist already.

"Let me do a physical exam and we'll see what we're looking at," Dr. Stewart said. "There's no blood or other test we can do to confirm ALS, but there are some telltale physical signs that we'll look for." He described the first one: involuntary muscle twitching. "Let's roll up your pants and take a look at your legs."

That's when I saw it. It was like tiny jumping beans were embedded under my dad's skin. After a moment of watching my dad's thigh dance to a tune no one could hear, the doctor moved on to other items on his list. It didn't matter though. I had never noticed it before, but now those jumping beans are all I can see.

Before this appointment I had read that the general prognosis for ALS was 3-5 years. My dad was 76. Five years would make him 81. I guess that's a pretty good long life, I had thought. Five years seemed like a long time.

"I don't understand though, he can still walk fine and there's nothing wrong with his arms," I said.

"I thought that's where ALS started—in the limbs."

"There are really two types of ALS. One is as you describe, where patients lose the function of their extremities," he says. "But the other starts with symptoms related to swallowing, speaking and breathing. That's what your father has."

When I do more reading later, I discover that my dad's form of ALS has a much more dire prognosis.

ESCAPE

Cassandra Tucker
Gadsden Arts Exhibition

Cassie Tucker is a watercolor artist living in Wakulla. Her art has been presented in five solo exhibits, four collaborative shows, numerous Tallahassee Watercolor Society Tri-state juried exhibits, and Regional Art in Gadsden exhibits.

My mother speaks up and mentions the trip they had planned to see family in South Dakota. “Can we still go?” she asks. The doctor says yes, the sooner the better. It’s early September.

It was less than three months ago when my dad went to see his primary care doctor. He’d been feeling short of breath and at times would stumble over his words. He was starting to get frustrated with himself.

At that appointment, my dad, mom, sister, brother and I all crammed into the doctors’ exam room. Knowing that my dad doesn’t always remember details and my mom is hard of hearing, we thought it better to have reinforcements. The doctor he’d had for years suggested that he had had a small stroke. Our focus then was to get him to see a neurologist to understand how we could prevent another, possibly bigger stroke in the future.

It took several weeks to get that appointment, and by that time, we were convinced it wasn’t a stroke, unless he had been having a new tiny episode every week that made his breathing and speech a little worse every time. The changes we saw in him were happening gradually, bit by bit. While the suggestion of ALS by the general neurologist fit dad’s symptoms, it was shocking. Due to a lifetime of bacon, red meat and cigarettes, I always figured his heart may give out one day, not his brain.

The changes came fast. My father had always been one for bear hugs, but now he didn’t seem to have the strength. He loved to eat good food (or bad food that tasted good), but he was losing his ability to swallow. He had the original “dad jokes” with his silly puns, but it was getting harder for him to participate in group conversations. They took the trip to South Dakota they had made countless times before, but I had to fly out to rescue them after my father had an episode and was hospitalized. At any typical Thanksgiving my dad would have stuffed himself with turkey and mashed potatoes then rested happily with a full belly and a wide grin. But this year he took just a bit of soft food and tried to eat where no one would watch him struggle.

One night when my young sons were asleep and I was ready to put the day behind me, the totality of his illness suddenly became real. I cried—hard—for a long time. As I fell apart, my husband let out a sigh of relief that I was finally exposing what he already knew was happening inside me.

A week after Thanksgiving, my father was back in the hospital again after what might have been a massive panic attack. All my family could be sure of is that he could not breathe and he was beside himself. At the hospital, they

sedated him to calm him down and make him comfortable.

They started asking my mother to make serious decisions about my dad’s care. With a terminal illness as horrible as ALS, there are no good options. We could do a tracheotomy for a breathing machine, continue feeding him through the feeding tube, and he could possibly go home. But the one thing I knew my dad did not want was machines and tubes. He had made that abundantly clear. We had to make decisions that were right for him, not us.

After a few days considering the terrible options and making awful choices, my family stood in the hallway outside his room, discussing a move to the palliative care unit. Caregivers there would focus on comfort care rather than restorative care. The nurses would not give him antibiotics for the infection that had arisen, they would not give him any other meds or nutrition through the feeding tube. They would just keep him comfortable.

I wasn’t sure if my dad knew what was happening, but I do know I wanted to feel close to him. I slowly slid myself onto his hospital bed and wrapped my arms around him. A “baby bear” hug. At 39, I’m his youngest “child” and I didn’t mind looking like one.

I put my face close to his ear and whispered to my dad how much I loved him. How I cherished his sense of humor and his generosity. I told him he was a great dad and that I was so, so lucky to be his little girl. I told him that I would make sure that my six- and three-year-old boys always knew that he loved them even though they might not remember him.

At the palliative care unit, they gave my father a room with a window looking out on a little garden area. It was calm and quiet there with nurses who were in tune with the gravity of their patients’ situations. Surprisingly, the atmosphere there wasn’t sad; just subdued.

Early Friday morning, a week after my dad went to the hospital, he took his last breath. My mom and siblings all gathered in his room before they took him away. I wanted to keep touching the areas of his body that were warm. Where there is warmth it seems there is still life.

As his fingers, then arms turned cold, I moved my hands underneath his core and could feel the warmth of his back against the bed. I pressed my hands in farther. He stayed warm for quite a while. ■

Sandra Meyers is a former journalist and long-time healthcare communicator. She lives in California with her husband and sons and is currently completing her MFA in Creative Nonfiction.

AFRICAN FEATHERED FRIEND

Randall Fisher, MD



BLUE MARLIN

Ryan Krumins
Class of 2022



BOWED BALD EAGLE

Debbie McCulliss

Debbie McCulliss holds master's degrees in nursing, science-medical writing, and non-fiction writing. A Colorado-based fine art photographer, she travels the globe to bear witness to and record the strength, fragility, beauty, and rhythm of wildlife and nature.



Saudade

Steven T. Licardi, LMSW

grief-inspired.

we can hold
two emotions
at once
in the heart's clumsy hands.

two delicate birds —
one living. one dead.

the same bird.
its bones like spun-glass.
chest dirigeable, full
of hot air.

my heart
is at once a fist
& a wing.
how do birds
express their rage?
how do they scorn
the sky?

by slicing clouds?
halving mists
into the same
whole?

my heart
is a knife now.

surgical, serene, & sanitized.

somehow, it still rests.
still sleeps each night
cradling itself. the want.
the uselessness. a weapon
without intent.

a fist
unclenched.

like a bird
holding a knife in its wing
attempting
to fly.

Steven T. Licardi is an Autistic social worker, spoken word poet, and performance activist working at the intersections of art and social policy. Since 2016, his ever-evolving performance series #CoupDeMot confronts how mental illness manifests out of oppressive social pathologies. Learn more at www.thesvenbo.com.

WE TALKED ABOUT THE TREES IN TALLAHASSEE

Rachael Sabra, Class of 2022

Medical school was not at all what I expected. There is more paperwork, bureaucratic red tape, and battles with insurance companies than I could ever have imagined. I did not comprehend this side of medicine as a youth watching *Scrubs* and wishing for a white coat. Now, three years into my medical school education, I have learned how much insurance companies and billing practices contribute to patient care. I realize the role our society plays in the final health outcomes of a patient. Stable housing, job security, social support, food deserts: to describe these factors as life or death seems dramatic but I'm not sure I have an alternative way of articulating the magnitude of these forces. These socioeconomic factors play a role in each and every patient encounter. I have also come to appreciate that the knowledge to navigate these systems is what distinguishes a good doctor from a great one.

The doctors that stood out to me during my third year in medical school were the ones with the knowledge of what medications are covered by the patient's insurance or which pharmacy can provide the drug free of charge. They knew which patients were non-adherent with the medications they had prescribed, but they also never lost patience or rushed an explanation. The doctors that made an impression researched products in order to treat patients with religious convictions against blood transfusions, wrote letters to state representatives to expand the clinical trial parameters of experimental therapies, and petitioned judges on their patient's behalf. The doctors that I idealized most volunteered at free clinics in their spare time and took time to answer any question that a patient could come up with. These doctors never gave up the fight.

And in this field, you have to fight for your patient's health more than I could have ever imagined. You have to fight for your patient against for-profit insurance companies and against the pervasive misinformation within our society. Some days you even have to fight with your patients, with

your stubbornness outlasting their own when you counsel them on the health benefits of smoking cessation for what may feel like the thousandth time. Your compassion and drive to help someone get better has to overcome more obstacles within the field of medicine than I could have ever thought was possible. You have to truly know your patients and work within the confines of their flaws. You have to appreciate the fundamentally human side of the medical field. Medicine is no longer the multiple-choice question and answer with which I have become so familiar. Medicine is an art made up of best intentions and well wishes with human error at its core.

The patient who showed me the type of doctor I would like to be was not unlike many of the other patients I have seen over the course of my third year. We made small talk about what school I attended and the beauty of the Tallahassee hills. I joked about walking to classes located on "Mount Diffenbaugh" and becoming short of breath. I told him the reason I chose to attend FSU as an undergrad was because of the trees. He mentioned his grandchildren and his wish to see them grow up. These comments were not anything out of the ordinary. In fact, I had had many similar conversations with patients in the past. But this patient was different from many of my other patients, even those within the walls of the Hematology Oncology clinic. This patient knew he was dying. Months ago he had been diagnosed with colon cancer. His doctors had found it in time and his prognosis had been good. He was prescribed a medication and was compliant with his appointments. Everything that had been written in the plan section of his SOAP note was falling into place. And then he went to prison. He had been arrested for possession of "crack" cocaine and served ten months. During this time his doctor had petitioned the judge in charge of his case repeatedly, asking for the patient to be allowed to receive treatment for his cancer. His request was denied. When the patient got out of prison several months later, the cancer had spread. He now had stage four colon cancer. His prognosis had drastically changed. And even among all the other patients with terminal diseases that had sat in that very exam room, this felt fundamentally unjust and unfair.

I've thought about that patient more than any other encounter in my entire life. I wonder how many others share this story. The justice system had changed a

punishment designed to reform a wayward citizen into a death sentence. The right diagnosis at the right time held hostage by an inflexible system with a deeply engrained disregard for human life. It had been a non-violent offense. The abuse of a substance that should have triggered a response of help or drug rehab instead of criminal punishment. We let this man down. We carried out capital punishment.

It had been a very inconsequential meeting, where we talked about the trees of Tallahassee, but it illuminated so much about our world. It showed me what I was up against. I can't change the entire structure of our legal system. I can't make drug prices more reasonable or ensure healthcare is an affordable cost for all my patient's regardless of insurance status. But I can help them navigate this world that at times can seem so treacherous. I can be the type of doctor that listens to their stories for more than the red flags necessary for a diagnosis. I can fight for my patients to receive care while incarcerated or get experimental treatments when they don't qualify for clinical trials due to their religious convictions. During this past year of medical school I learned from the best how I can fight for my patients. And I will remember the patient that inspired me to be a better doctor every time I think about the trees of Tallahassee. ▪

COSTA RICAN RAINFOREST

Ryan Krumins
Class of 2022

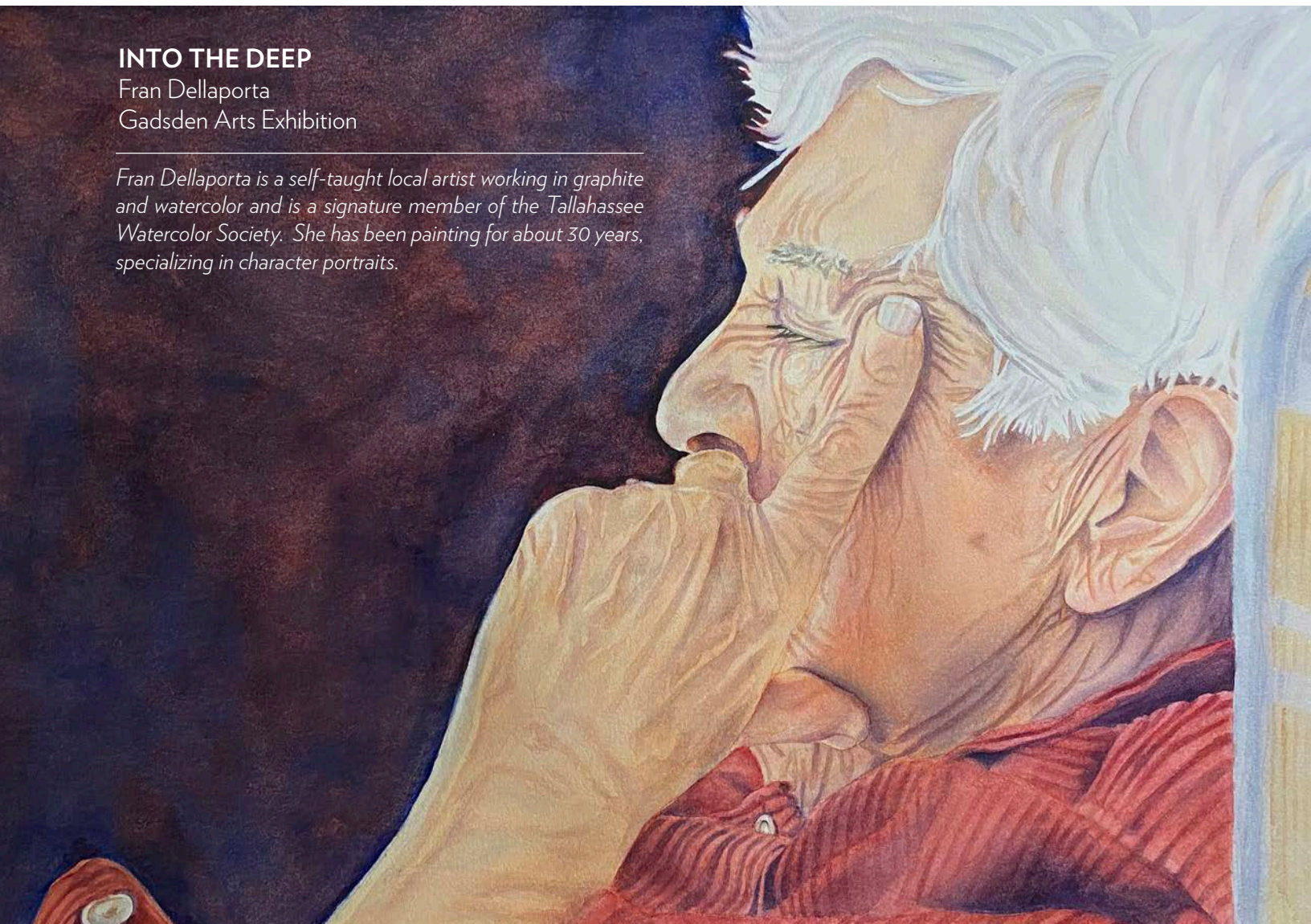


2020 COVID REDUX: THE BREADLINE
Chuck Wells, MS
Program Director, Science and Research Development

INTO THE DEEP

Fran Dellaporta
Gadsden Arts Exhibition

Fran Dellaporta is a self-taught local artist working in graphite and watercolor and is a signature member of the Tallahassee Watercolor Society. She has been painting for about 30 years, specializing in character portraits.



Reflection Upon the Crash

Louis Gallo, PhD

When I revisited the site of the crash
as one returns to the scene of a crime
a fist of icy voltage clutched my spine
in memory of what I, knocked out cold,
can't remember lest retold in the flesh
as we, my girls and I, paused on that road
not for long, not to grieve
but rather to appease some god of old
demanding thorough commemoration
of what might not have happened a second
later, sooner, or another day,
what might never have happened at all
save for the vulgarity of chance.

The battered love seat lured me back
when home again—it's where I sat
with fractured bones and opiates.
Back home I moved as if in a trance
toward the battered love seat where
I'd spent weeks mending battered bones
that were wrecked—and here I lie once more
thinking, re-thinking and at last
not thinking about the cataclysm that
gave me vision to see and foresee what
the future portends, the silky smoke and ash
of death and transfiguration, mere trash
when set against the sight of a sparrow
lighting upon a branch of the blue-green yew
in our yard or that faun who leapt the fence
to nibble upon the marrow of our lilies.
All it seems is settled in a moment,
for good or ill, the moment, its monument.
Fail to notice each and you live in vain.
Pain and pleasure are the same.

Dr. Gallo is Professor of English at Radford University in Virginia. He is the author of four volumes of poetry, including Crash and Clearing the Attic.

STAIRS. ST. AUGUSTINE LIGHTHOUSE

Michael Hayward

Michael Hayward holds an MBA from the University of North Florida. He is a Certified Financial Planner(®) and the proud parent of Anna Hayward, FSUCOM Class of 2022.



LET'S GIVE HER A HAND

Dominique Catena, Class of 2022

During my Summer Clinical Practicum of the M1 curriculum, I engaged several patients in a “no agenda” interview. In this style, the line of questions in a traditional patient encounter such as “What brings you in today?” or “What health conditions do you have?” are replaced in favor of hearing a person’s story. Hearing the varied responses for each patient opened my eyes to the greater scope of clinical practice. I realized that the narratives this question produced were rarely the chief complaint listed on the chart.

As these visits occurred before I gained access to the facility’s electronic medical record, I had the added benefit of going in with no prior preparation. I was able to hear Ms. C’s entire situation in her own words. The nurse suggested she was present for a simple follow-up on labs that assessed her blood thinner levels, since she has been on warfarin chronically. Admittedly, I did not think I would receive much of a story from an 83-year-old woman who arrived for an ‘INR check’.

Dutifully, I began the no-agenda interview with the following prompt: “Please tell me what you think I should know about your situation.” She was polite but curt. “Everything’s fine,” she reported; though she sat rigidly in the chair with her pocketbook in a white-knuckled grip on her lap. It seemed only as we sat in brief silence, when she realized I intended on sincerely listening, that she began to quietly cry. In the moment I had taken to glance at her lab values, I almost didn’t notice the silent tear rolling down her cheek. As a newly minted second year medical student, I was so stunned that I had to ask, “Do you need a tissue? Are...are you crying?” She only nodded. Frankly I was shocked. Not only was this the first patient encounter I’d had alone with a crying patient, but it was striking to me that what started out as a lab work

SPRING I

Ghazal Farajzadeh
Class of 2023

follow-up turned into this patient confessing her fears. As I scurried for tissues, she relayed, “My husband has dementia so I’m his caregiver. It’s just been so hard with all my health problems.” She told me that her most recent visit to another provider gave her greater concern over her atrial fibrillation (AFIB, an irregular heart rhythm) and a recent scare with malignancy. She noted, “It all just made me so scared, I didn’t know what to do. I got worried it would just make my AFIB worse.” The combined stressors had amplified her worries about her heart. Her terror became intensely real as she began to sob now, “I was so scared that I just stopped doing anything. What if my heart gets bad and I die? Who will take care of my husband?” Admitting that she was so petrified of exacerbating her AFIB, she had stopped all physical activity she enjoys; I envisioned this weeping woman, sitting at home paralyzed in fear.

Early on in our medical education, we are taught the utility of ‘SOFTEN’ skills. This acronym refers to Smile, Open body language, Forward lean, Touch, Eye contact, and Nodding. It’s often taught didactically with some small group discussion. As with many components of medical school, these skills are only truly understood once applied. And while I’d had the opportunity to use ‘SOFTEN’ skills with patients before, this was the first encounter I used Touch in that context. I gave her a tissue and then held her hand while she told the rest of her story. Every so often she’d squeeze my fingers, and I understood the contact aspect of rapport for the first time.

In the age of COVID, our relationship with touch has changed drastically but appropriately in the name of infectious control. And though the reasoning is sound, it does not lessen the blow that the lack of physical contact leaves. I learned in this encounter that touch is an integral skill in the clinical toolbox of a physician. And now during clinical rotations in the pandemic era, the moments in which I would otherwise embrace or hold the hand of a mourning or distressed patient leave me feeling bereft of such a basic instinct. This is not the new normal, yet it has shown me the value of human contact a thousand-fold. More than a tool, engaging in the therapeutic intervention of human touch is not only a basic right but a privilege for providers.

Continuing her story, Ms. C noted, “I’ve been so upset that I think I missed a couple doses of my warfarin.” So consumed by other anxieties, she was clearly unbothered by another task of taking medication. I began to piece it together. Perhaps the INR—the whole reason for her visit—was too low for the blood thinner to be effective because all the distress caused her to forget her warfarin.

Not only did this address the reason for her visit, but also it was expressly through this anecdotal experience that we were able to ascertain her true concerns and address the decline in her quality of life.

Although following basic guidelines for patient dialogue gave me some useful information for working with Ms. C, it felt as though the “no agenda” style of interviewing and active listening were what permitted Ms. C to realize that I was there to listen to all aspects of her life which affected her health. Clinical guides, lectures, and textbooks do not cover how to address an emotionally distressed patient, but I realized in that moment it was not nearly as technical—just being sincere and extending an open-ended offer to share her narrative was enough to prompt the genuine reason for her visit. I have found value in employing most parts of ‘SOFTEN’ skills in my encounters, but “Touch” was one I had not yet used. All the skills in this memory device have utility in practice, but only touch directly brings together physician and patient in a tangible solidification of trust, acceptance, and understanding. Topically, it may appear trivial, but it was a poignant experience to see both the comforting effects and easing feelings of isolation when I held her hand. I firmly believe it was the use of touch, coupled with the simple open-ended request, which helped to establish the connection which made Ms. C comfortable enough to share her story.

This encounter in particular demonstrated the importance of using this interview style on even the most seemingly ‘routine’ visit types. After seeing firsthand the positive effects of narrative competence in the practice of medicine, I too can advocate that this method of interviewing is not only effective at addressing patient concerns, but helps them to feel heard and involved in their plan of care. Every patient is first a person, each with their own story. And while they are all unique, they share the commonality that we, as providers, need simply to listen. ■



LADY IN THE GARDEN

Chaitali Hambire, MDS

Wound Nurse

Joanne M. Clarkson

Skin is my task, my challenge, calling
within my nursing vocation.
My grandmother was a seamstress.
My talent is the mending
within her genes. My patient today:
an 83-year-old woman, living alone,
who fell and could not rise,
who, throughout the night,
crawled across rough carpet
scraping away her skin.

First, I offer assurances,
I am here to help.
She nods her permission.
Gently I cleanse the abrasion
easing out dust and fibers.
Sensing pain, I explain to distract,
salves of honey and silver,
one to feed as the other disinfects,
gifts from a nurturing earth.

Skin is the body, its largest organ.
Others argue the importance
of heart and brain, bone and kidney,
digestive tract. I practice what I
believe, cover the wound
with a non-adhesive pad. Wind
and secure the gauze. Promise to return
tomorrow. But my visit is not complete.

I touch her shoulder, create electricity
between us in the pulsing, vibrant nerves
alive within her dermis. This
is the place where we trust the world
or turn it away. And I know
through working wisdom, nothing
holds the soul like the miracle of skin.

Joanne Clarkson's fifth poetry collection, The Fates, won the 2016 Bright Hill Press Poetry Award. She worked for many years as a registered nurse in home health and hospice care. See more at www.JoanneClarkson.com.

THE WAR ON COVID

Maheen Islam, MD

Dr. Islam graduated from the College of Medicine in 2021 and is currently a resident in psychiatry at the Mountain Area Health Education Center in Asheville, NC.



THE CAGES THAT TRAP US

Nafisa Choudhury

Nafisa Choudhury is a medical student at the Dr. Kiran C. Patel College of Allopathic Medicine Nova Southeastern University in the class of 2022. She is particularly interested in the intersection between visual arts and medicine and the commentary this interplay provides.



A Shoulder to Cry On

Tabor Flickinger, MD, MPH

I rest my salty zygomatic arch

Within the welcome hollow where

Your pectoralis and your deltoid touch

While, deep to me, your polarizing plexus

Sparks down myelin sheaths, each flare

Excites its motion: one extends, one flexes.

Thus, your arms embrace me. Thus, you knead

My tense trapezius and from

Your fingers all distress of flesh recedes.

Our vagal nerves seep comfort, slow our hearts.

They beat together: we become

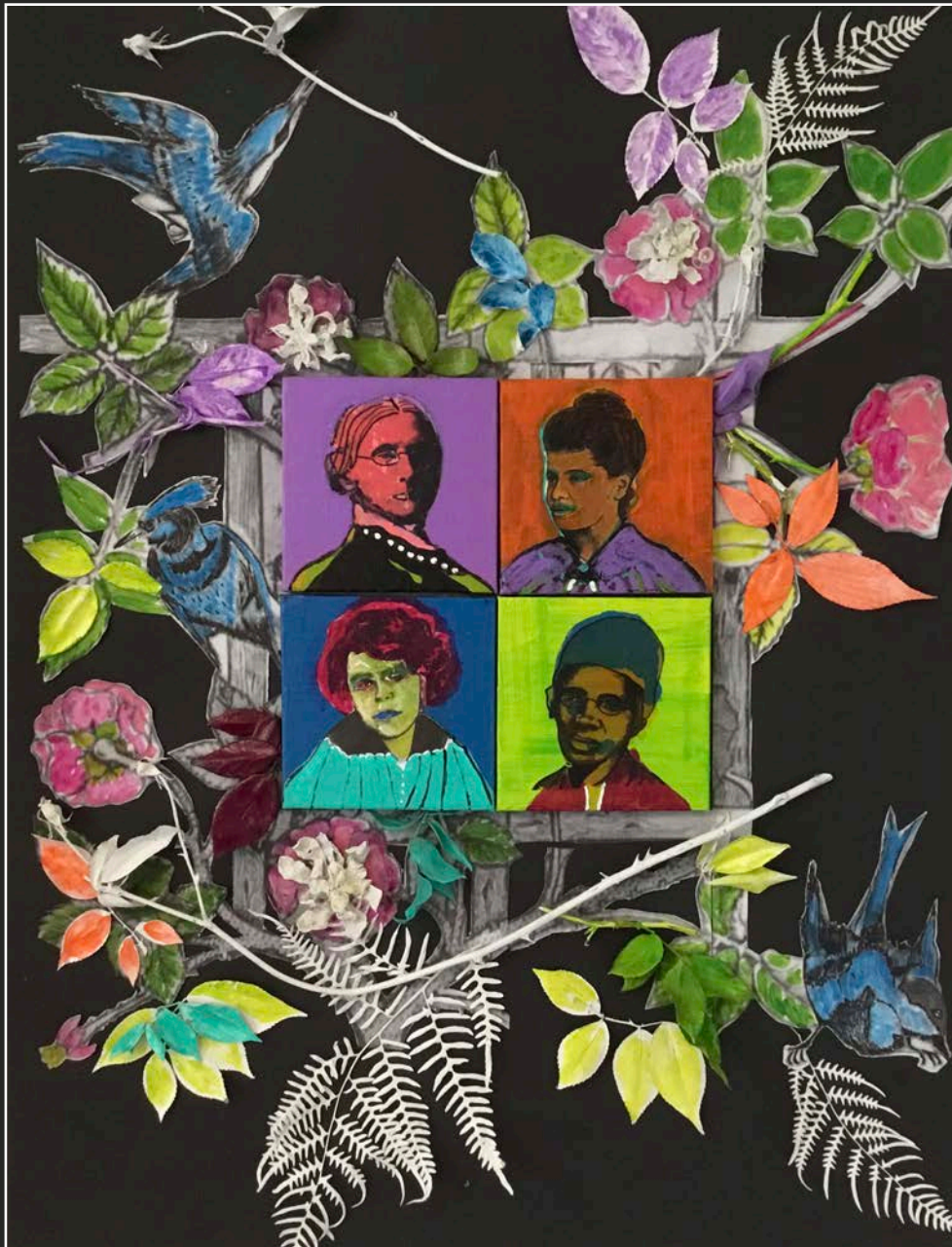
More than the sum of these, our mortal parts.

Dr. Flickinger is a physician and clinician-educator at the University of Virginia School of Medicine in the division of General, Geriatric, Palliative & Hospital Medicine. She enjoys writing as a form of self-care and a way to share a humanistic worldview with others.

PULSE MEMORIAL, ORLANDO, FLORIDA

Michael Hayward





**SUFFRAGETTE WALLPAPER II:
THE SUFFRAGETTES MEET ANDY WARHOL: SUSAN B. ANTHONY, IDA B. WELLS, ALICE
PAUL, SOJOURNER TRUTH**

Nancy Jones
Gadsden Arts Exhibition

Nancy Jane Lee Jones is a mixed-media artist working in the rural Florida panhandle. Her work focuses on women, telling their stories and illuminating their hidden histories.

**WE COULD HAVE DANCED
ALL NIGHT**

Carole Saville

Photo by Michael Hayward



Carole Saville is the director of the Florelines Guild of the St. Augustine Garden Club, and a former librarian at the Mayo Clinic.

PATIENTS BEFORE

Personal Sorrow

Jennifer Caputo-Seidler, MD

"Life comes before any personal sorrow! Come, I ask for courage, for heroism! For the love of humanity!"

- Anton Chekhov, "Enemies"

My alarm broke the silence of the early pre-dawn hours. I opened my eyes, then lay in the dark, bargaining with the universe for more sleep, for the chance to postpone the reality of the day just a little bit longer. It had been twelve years, but I still woke that summer morning overwhelmed with the thought, "I miss my Dad."

But that month I was the MICU senior and I had no choice but to submit to my alarm, get up, and head to the hospital, my heart heavy, my mind distracted. I knew I wasn't at my best and I prayed for the strength and guidance to care for my patients as though it were any other day.

As usual it was a busy service, including a new patient, Ms. A, admitted the evening before with respiratory failure after an elective procedure. She wasn't doing well and had declined steadily throughout the night. As my team prepared to set off on rounds, Ms. A's latest chest x-ray revealed a new large, left-sided pneumothorax. We went to her bedside first and placed a chest tube, relieving some of her respiratory distress. We reviewed the remainder of her care plan, spoke with her nurse, placed orders, then continued on with rounds.

We managed to see another two patients before the ER called with a critical admission. A man in his mid-30s with granulomatosis with polyangiitis had presented to a small outlying emergency room, coughing up massive amounts of blood. He'd been intubated and air lifted here for further care. My team quickly abandoned rounds and walked to the ER.

Our patient, Mr. S, lay on a stretcher in the trauma bay. He was intubated, his oxygen saturations were in the 60s, and there was blood in his endotracheal tube. Calls were made to the blood bank and to interventional radiology for an angiogram. We wheeled Mr. S to Interventional Radiology (IR) ourselves, not having time to wait for transport. Our IR colleagues had a room immediately ready, but the attending could not find a source of bleeding to embolize. Our diagnosis: diffuse alveolar hemorrhage. We brought Mr. S up to the ICU, and as we were getting him stabilized, the intern answered a page.

She hung up the phone, "They need us downstairs for Ms. A. NOW."

Our team finalized our work to ensure that Mr. S was stable, and as we headed toward Ms. A's room, a code blue was called overhead on her unit. We broke into a run. When we arrived to Ms. A's room, chest compressions were underway. We joined in the resuscitation efforts, rotating in giving chest compressions, calling for epinephrine, and placing a femoral line. Several times her pulse returned, only to be lost again within minutes. We had been resuscitating Ms. A for nearly an hour when her family arrived accompanied by our chaplain. One of her sister's began screaming, "Don't leave us" over and over again as she collapsed to the floor and sobbed in the hallway behind us.

But there was nothing more we could do. Ms. A had died.

As we stopped the code and withdrew from the room, Ms. A's family members threw themselves upon her body, crying and calling out in pain and grief. Tears ran down my face as I bore witness to their loss from the periphery of the room. When the family was ready for privacy with Ms. A, I ran to the bathroom and sobbed. My shoulders heaved until I couldn't catch my breath. My eyes turned red and puffy. Snot ran down my face. I stayed in the bathroom like that for about 15 minutes. Then I washed my face, collected myself, and returned to the workroom.

My team, looks of surprise on their faces, asked if I was alright. I explained it was the anniversary of my father's death and that the code had brought up a lot of those emotions for me. My team offered support, got me a glass of water, told me I'd be okay.

Then the pager went off.

"MICU returning a page," I answered.

"Mr. S is bleeding again," the nurse on the other end told me.

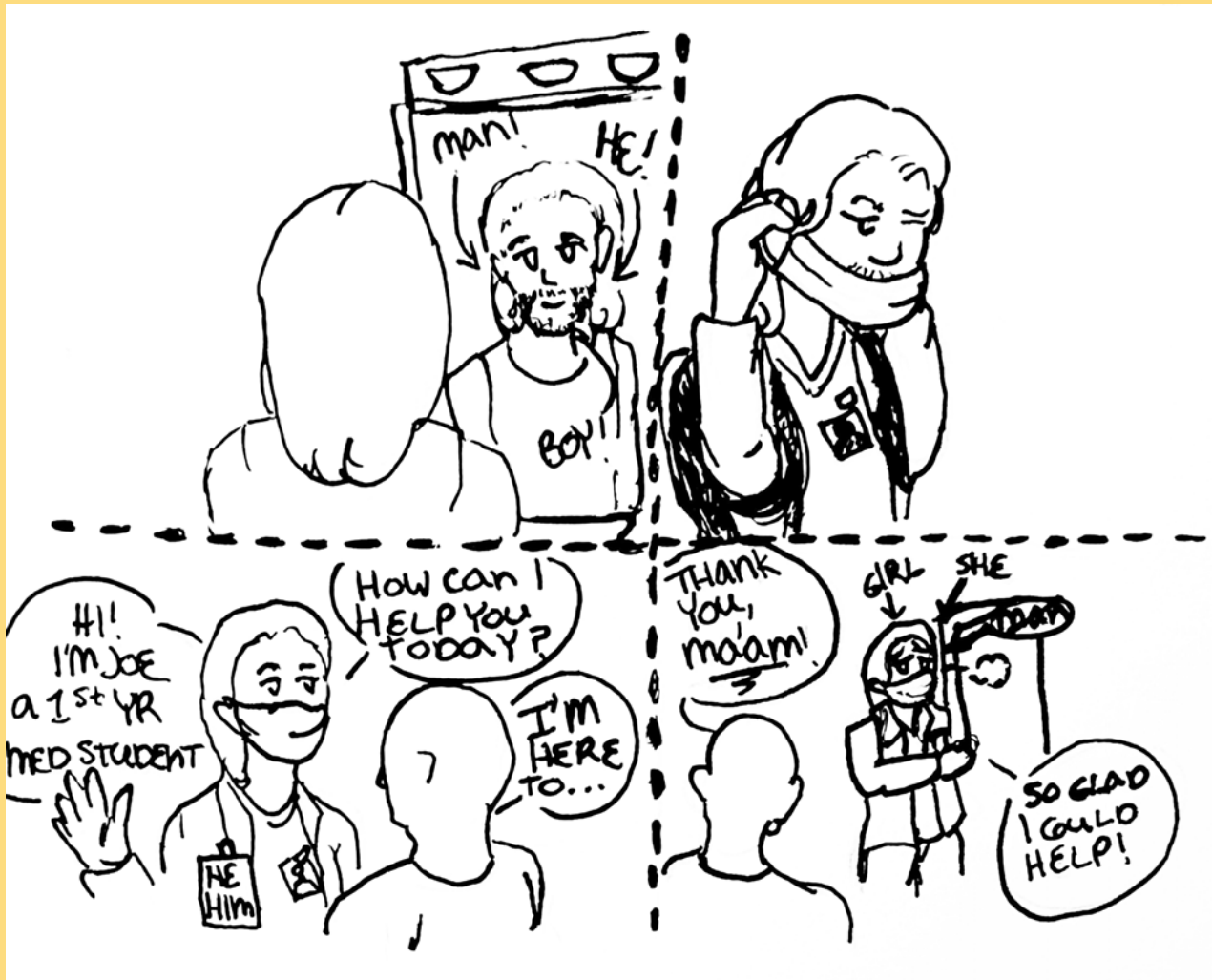
"We're on our way," I hung up, grabbed my white coat, and headed for the elevator, the rest of the team at my heels.

There was no time for my grief. ▪

Dr. Caputo-Seidler is a hospitalist at the University of South Florida. Her interests include narrative medicine, gender equity, and medical education.



GRAPHIC MEDICINE



UNMASKING DYSPHORIA

Joe King
Class of 2024



BEING A MEDICAL LIBRARIAN DURING COVID-19

Susan Epstein, MSLS, AHIP

Charlotte Edwards Maguire Medical Library

Susan Epstein is a medical librarian at the FSU College of Medicine. She analyzes, documents, and modifies e-resource, instructional, and website processes for the Charlotte Edwards Maguire Medical Library.

BARRIERS

Daniel Oheb

Class of 2024

University of Arizona College of Medicine, Phoenix

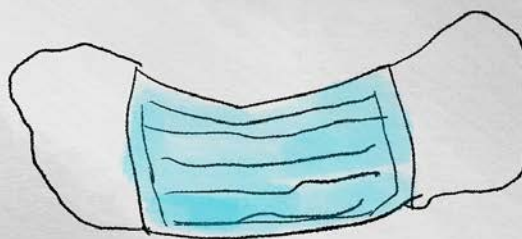
Daniel Oheb is a second year medical student at the University of Arizona College of Medicine-Phoenix.

I've lost count of how many hours I've sat at my laptop



How many times I've wanted to just throw it out my window and just go outside

I want everyone to be safe, but I miss seeing people smile



I get startled whenever I see someone's whole face

Even when I'm with a patient in person, it still feels like I'm looking at them through a screen



I can barely see them.

It feels like I'm barely even a medical student

Things will get better.

I'll make it over...

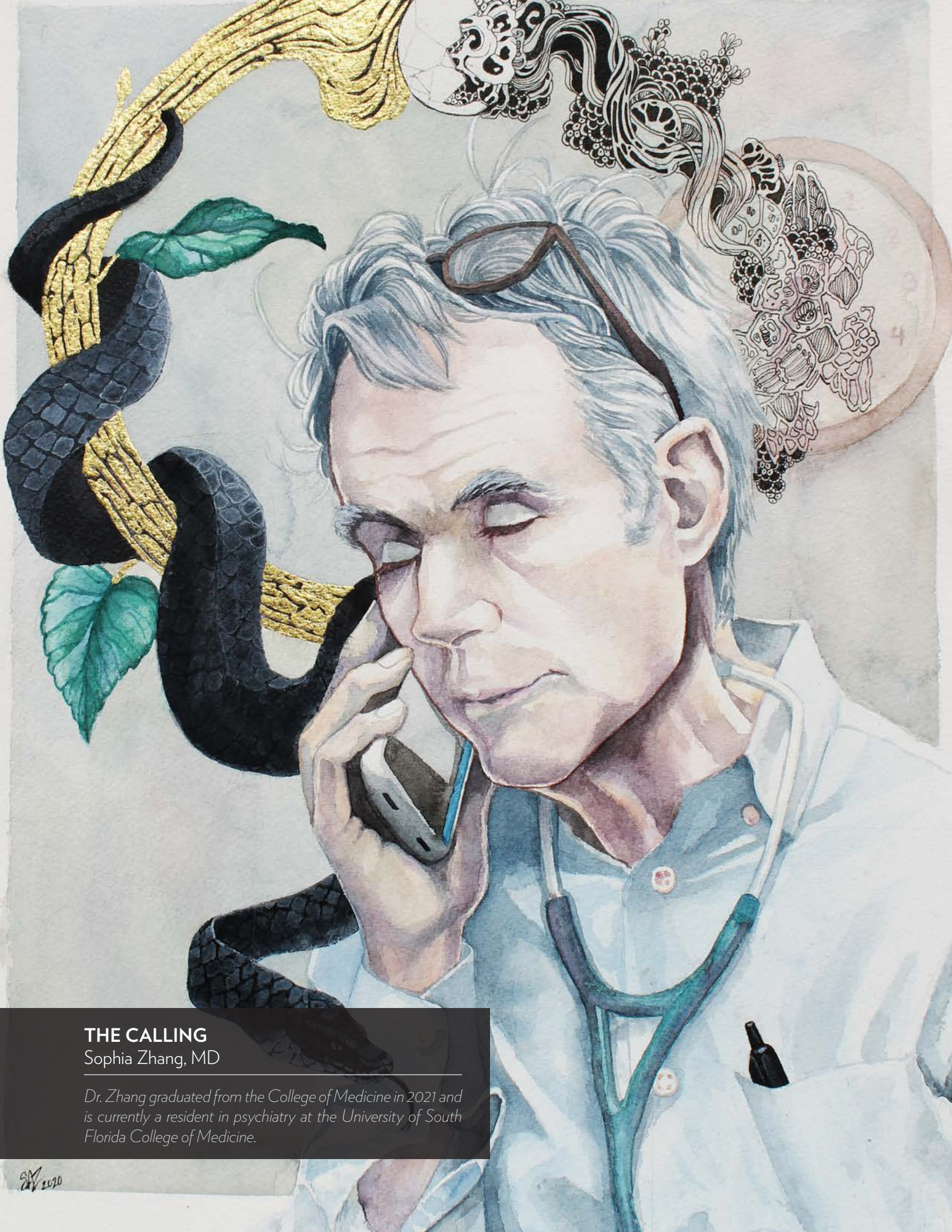


But I know that I am.

The barriers will come down.

to the other side.

PH 6/20



THE CALLING

Sophia Zhang, MD

Dr. Zhang graduated from the College of Medicine in 2021 and is currently a resident in psychiatry at the University of South Florida College of Medicine.

Scaling Pain

Suzanne Edison, MA, MFA

In the doctor's office, as an adult,
they ask me to rate my pain from 1-10,
pin it down, stick a flag
in the country of my worst,
the badlands of sand storms and fire
or the swept out middle
where a tornado passed
shy of the house, roof still shingled.

But you, my son, are not
grown, and the chart for kids is faces—
at one end, a smile, and at its opposite,
a tear-strewn frown
which may describe your face
but not your knees, drum sticks
throbbing as you hobble
towards the school entrance,
late, most mornings, or the effort
of unlatching your backpack,
fingers swollen as pickles, or
the way your heart wrenches and seals over
when a classmate teases you for being slow.

I do not see your pain
as a straight line mouth of resignation
eyebrows humped up as if querying
your right to feel
between these lines.

I have learned to read
your eyes' stoic dullness, discern
the firecracker flints of irritability
or joy, knowing you live
everyday, feinting, shifting and pulsing
in a sparring ring.

Suzanne Edison's poetry collection, Since the House Is Burning, is forthcoming in 2022. She lives in Seattle, is a Mental Health Coordinator, and teaches poetry workshops on illness, trauma and healing through the UCSF Chronic Illness Center and Seattle's Richard Hugo House.



Cover
Artwork
Finalist



On the Back Cover

MEMENTO MORI

Samantha Snow
Class of 2024

Samantha Snow is a second year medical student at the FSU College of Medicine.

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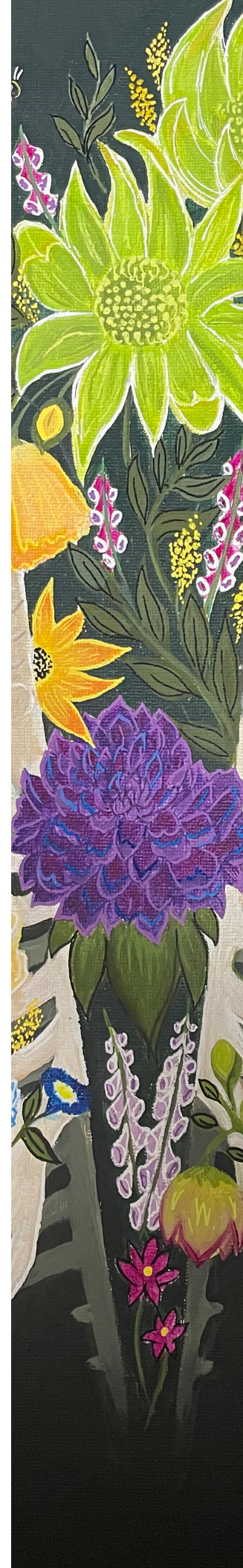
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