Literary Liniment

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Note from the Editors

The medical humanities has been a growing field over the last few years, becoming a place for healthcare professionals and trainees to reflect, process, explore, and grow during their training and careers. The healthcare field is a rigorous place for trainees and professionals alike. Unfortunately, given the demands of medical training on time and energy, opportunities to reflect upon the deeper meaning of the professional experience within medicine are often few and far between. However, such opportunities are pivotal to reviving and maintaining the heart of medicine. Our human dimensions as healthcare professionals not only enable us to provide compassionate care for our patients, but also allow us to maintain our own sense of identity and well-being. Through this anthology, we hope to show how the emerging generation of medical professionals is interested in using the medical humanities to explore deeper issues of meaning, self-care, and the shared humanity between ourselves and our patients.

We received an overwhelming number of submissions of fantastic quality and content from medical and graduate students as well as healthcare professionals from institutions all over the world. Through poetry, narratives, short stories, and visual arts, this anthology provides a small peek into the realm of healthcare and the issues, events, and emotions that are experienced on a daily basis behind the walls of hospitals as well as out in the public world.

The original idea of this medical humanities anthology "Literary Liniment" was borne through the participants of the American Medical Student Association (AMSA) Medical Humanities Institute in 2013. The anthology has ultimately become a reality as a result of the four of us student editors who came together during the AMSA Medical Humanities Scholars Program 2013-2014. We also received a great deal of guidance and support through our two advising mentors, James Borton (Writing Instructor at Coastal Carolina University and Editor of *The Art of Medicine in Metaphors*) and Nina Stoyan-Rosenzweig (Director of the Medical Humanities at the University of Florida College of Medicine). Importantly, this project would not have been possible without the funding provided by the Arnold P. Gold Foundation. And last but not least, we are ever so grateful for the assistance provided by University of Florida staff and faculty: Karen Dooley (Director of Development and Alumni Communications at the College of Medicine and editor of the *New Physician* alumni magazine), Jill Sonke (Director of the Center for the Arts in Medicine at the University of Florida), Lucinda Lavelli (Dean of the College of the Arts), Jennifer Coolidge (Coordinator for Development & Alumni Affairs at the College of the Arts), and Victoria Masters (Accounting Coordinator at the College of the Arts).

Dr. Rachel Remen, a champion of the medical humanities, has an approach to daily journaling that we have found particularly salient through our work on this anthology. Each day, she suggests that you write about something that inspired you, something that surprised you, and something that touched your heart. We hope that in joining us in our endeavor toward a meaningful and compassionate practice of medicine in the context of the humanities, you are able to find one—if not all—of these things through your reading of this anthology.

-Literary Liniment Editors Team

1. The Proof of Humanity

LET'S START

Trang N. Diem Vu

A lady in a pristine suit appears in the doorway
and calls my name. As I clumsily gather
my brochures and pens, she greets me,
introduces herself and asks,
"Ready for me to ask you some questions?"
She leads me to a small office,
the walls crowded with degrees and plaques,
the desk lined with smiling faces in fine frames.
She leans forward and rests a notepad in her lap.
"Let's start. Tell me your story.
"Tell me why you want to be a doctor."

A lady with a stethoscope appears in the doorway
and calls my name. As I quickly fold up
the magazine in my hand, she greets me,
introduces herself and asks,
"Ready for me to ask you some questions?"
She enters the small exam room,
glances at her pager before tucking it away,
swings the chair at her desk to face me.
She leans forward and rests a notepad in her lap.
"Let's start. Tell me your story.
"Tell me what brought you in here today."

A lady in a white coat and scrubs appears in the doorway
and calls my name. As I hastily gather
my notebook and pen, she greets me,
introduces herself and asks,
"Ready to ask me some questions?"
She leads me from the small office,
through bright, buzzing staircases and halls,
into the bustling preoperative holding area.
She stops at a room and rests her eyes on me.
"Let's start here," she whispers.
"Let me tell you this patient's story."

HEART SOUNDS

Gabrielle Langmann

In the middle of my third year of medical school, I spent a month doing an elective in pediatric cardiology. The majority of my time was spent in the hustle and bustle of outpatient clinic, where as many as five attending physicians at a time would be seeing their patients for follow-up. I was given permission to roam freely, picking up any patient I wished to see and present back to the attending.

Over the weeks of my rotation, my decision to pursue training in combined internal medicine/pediatrics was confirmed. I saw days-old infants as well as adults in their early sixties, all unified by the experience of living with congenital heart disease. I became completely enamored of the physical exam of these patients and just how much a person's heart could reveal if only one would take a moment to touch and to listen. I was astonished at how much I had missed back when I had clumsily picked up my stethoscope for the first time during my first year of medical school. The crispness of mechanical heart sounds. A thrill palpated at the left sternal border, like a burbling creek running underneath the heel of my hand. The regurgitant flow across a semilunar valve, so very soft and low-pitched in the shadow of diastole, the relaxation phase of the cardiac cycle. Feeling the femoral pulses of a four-day-old baby like the lightest of taps against the flesh of my fingertips.

One afternoon, I saw a fourteen year-old girl who expressed to me that she was thinking about becoming a pediatrician. Ecstatic at the opportunity for a captive audience, I made a crude box drawing of the heart for her and explained that the sounds for which I would be listening—the "lub dub, lub dub"—were the sounds of her heart valves closing and opening, closing and opening. I began to listen to her heart carefully, the individual components of her second heart sound moving closer together as she exhaled, but never fully becoming one. I finally asked her if she had ever had an opportunity to listen to her own heart. She said no. I smiled, taking the ear buds of my stethoscope out of my ears and placing them into hers. After a few seconds, her face broke out into an unadulterated grin. "Can you hear it?" I asked. She nodded, not wanting to interrupt what she was hearing with extraneous noise. I'll often give my patients who are known to have "interesting" physical exam findings (and therefore have swarms of white coats flocking to their bedsides to sneak a listen) the opportunity to hear what all of the fuss is about, but I have never seen someone so enraptured with the sound of her own heart. It was beautiful to watch. I'd like to think that this moment was meaningful to her, something she might write about in a personal statement some day. Her joy reminded me of the constant privilege it is for me to continue on this journey as a physician-in-training.

My clinic visits were not always this joyful. I had one morning in clinic during which I saw a middle-aged woman who was born with a congenital heart disease called tetralogy of Fallot, which caused her body to receive suboptimal amounts of oxygen for many years until she underwent complete surgical repair three months prior to this clinic visit. She was soft-spoken, but amenable to speaking with me. She expressed that she sometimes skipped doses of her medications, most namely her anti-arrhythmic drugs, which eventually gave her recurrent palpitations. She also admitted to not keeping many of her cardiac rehabilitation appointments. As I try to do with every patient I see, I asked about her mood. It became very clear to me then that she was severely depressed: she slept all day and lay awake through the night, had lost interest in pleasurable activities, had little to no energy, and felt such extreme guilt about receiving disability that she wondered if "it would be better if [she] was no longer around." We talked at length about her sources of support and what was keeping her safe. Eventually, I asked her to sit up on the exam table so that I could perform a physical exam. Her cardiovascular exam was remarkable: she had a palpable thrill and right ventricular lift, a loud and harsh systolic ejection murmur which reverberated throughout her chest, back, and carotids, and she had mild clubbing of her fingernails, formed by the biofeedback molecules her chronically oxygen-starved cells had been spitting out in protest for years. Despite all of this, after I reported back to my attending and returned to see her with him, I felt as though I had had a better listen to her heart fifteen minutes earlier, when my stethoscope was still lying limply around my neck.

During my elective in pediatric cardiology, I came to realize that I'm perpetually listening to the hearts of others. No matter what rotation I'm on, I have this bizarre and amazing opportunity to go from a knock on an examination room door as a stranger to being privy to the inner joy and sadness of others, in the space of approximately twenty minutes or less. It humbles me to realize that all of the hundreds of patients I've had the privilege to meet during my medical education have allowed me to touch and to listen to their hearts, both physically and metaphorically. Most importantly, though, they do this so that I may learn to heal them.

Sometimes when I'm alone following a long day at clinic, I'll pick up my stethoscope and place it on my chest, listening to the ebb and flow of my own heart sounds. I feel for the pulses at my wrists, behind my ankles, on my feet. I don't think that I'm looking for the clinical correlation of knowing I'm alive and healthy so much as I'm seeking confirmation that I, too, share in this same humanity with all of my patients, no matter their age or the stories that linger inside of their hearts.

CATCHY

Sara Raiser

She was not even my patient. We had rounded on her day in and day out for my entire stay on the internal medicine service. She had lung cancer, whisperings of HIV, and numerous other comorbidities. She was in and out of consciousness, refusing to talk to the team on most occasions and resisting physical exams. She eventually had to be placed in soft restraints to prevent her from removing her intravenous lines and feeding tube. She was miserable.

I found it difficult to watch the physical exams even though the residents and attendings were very gentle and kind. The resident caring for her was incredibly kindhearted and considerate and always spoke of her with respect. He always did his best to provide her with the most thorough and appropriate care possible.

Then, on my last week on the service, she spoke. She opened her eyes, albeit weakly, and painstakingly turned her head toward our attending: "I was really sick, wasn't I?" I was throat-choked and tears stung my eyes. This was one of those moments when the hard truths are shoved in your face. This is why humans go into medicine. Moments like this. Raw human reality, emotion.

I felt almost silly as our team filed out of the patient's room. I was asked a question and, of course, choked on my answer. My fellow resident team member provided confident words: "See, this is how you know you chose the right profession. This is what it is all about". I smiled weakly, still trying to keep my catchy breaths under control. "Yes, I suppose it is."

A PHYSICIAN TO LISTEN

Jonathan Rose

She sat staring in our direction, though I knew she could not see us. The interpreter sat in front of Amy, head turned to glare at us over her shoulder. I was sweating in my discomfort. When Dr. Green had said that we were seeing someone who was "deaf-blind," I never imagined that we would be sitting here in exam room eleven, being scolded in perfect English. Amy could not see us, but her interpreter could. The interpreter could see everything: the exasperation on Dr. Green's face and the shock on mine. I was surprised, not by the harshness of Amy's words or the way she contradicted Dr. Green, insulting his years of education and experience; I was astonished by how articulate she was when she spoke—clear and sharp, with precise pronunciation and all of the proper intonations and pauses. She rocked in her chair and spoke calmly with a polished delivery that you would not expect from someone with her impairment.

Her clarity of speech had taken me by surprise, but more than that, I was struck by the coherence of her rebuke and its depth of substance. It was as if she was reading from a script on the back of her closed eyelids—one carefully crafted well in advance, the message refined and edited. Dr. Green had not prepared me for such a formidable attack. He had told me the basics: she had a rare genetic disorder, deaf since twelve, partial vision loss at sixteen, and after having a baby a year ago, loss of the rest of her sight along with temporary paralysis. She had recently regained some movement, but was now in severe pain. He had said that she might be upset, after riding the carousel of specialty consults, only to wind up right back here without a diagnosis or obvious path forward. I could tell by the way his single eyebrow furrowed as he told me her story—this particular case was getting to him. He was doing everything that he possibly could, but there seemed no plausible reason for her pain. Every test had been run, every pill given. What more was there to do?

Despite his frustration, Dr. Green tried. With genuine sincerity, he pleaded with the interpreter, "Tell her I am sorry- the tests have all come back negative. Tell her that I admire how brave she is. Her strength is an inspiration. Tell her that I haven't given up yet. I will find an answer to where this pain is coming from." Her interpreter signed these words. Amy's hands rested on the interpreter's, dancing along in palpation, grappling for the meaning as she squinted to understand. Finally, her eyebrows sharpened, and she glared at him behind closed lids. She spoke with focused cadence, "What is there to be inspired by? I was given this body, and I can do nothing but live in it." She stopped rocking. "Yes, it has betrayed me, made me its foe, but there is nothing here to pity. I live a full life, with a son and family that love me, interests that stimulate me, and simple pleasures to sustain me. But right now, I am a person in pain, a patient who wants her doctor to listen."

As she continued, she began from the beginning. She told us how she lost her hearing completely as a child, and how her sight slowly deteriorated throughout high school but that its loss had ultimately halted, leaving her with a blurry gaze. After this, she was still able to distinguish far off shapes and shadows, and in what was the best gift she ever received, she was left with the ability to read up close. She spoke of how she went to college, double majored in psychology and early childhood education, how she moved to Boston for work, and there, met her husband. I tried to imagine this man. He must be deaf too. I imagined them picnicking at the common, signing and laughing amid the silence of the bustling city. She told us how they had wanted a child--something whole they could make together.

They struggled through two miscarriages, but eventually had a healthy baby boy. Though she couldn't hear him, she was able to watch him take his first breath as his tiny body quaked with sobs. She told us how she held him and gazed down through fuzzy eyes at his perfect face, It was the most beautiful thing she had ever seen—and one of the last things she ever saw. Shortly after delivery, with baby Shawn warming in the hospital nursery, she had awoken from a nap in darkness with her vision gone and body paralyzed. She told us how she had laid there in silence screaming, unable to move, unable to communicate with the outside world.

I thought of her lying there alone—blind and struggling to lift her hands. I thought of her wanting to see, to speak, to at the very least touch something. I felt my throat tighten. I choked it back. Absolutely not. Not here, not now. But the harder I fought it, the more it battled back, bubbling up, until streaks began to flow down my cheeks. I hated myself for it—for my weakness, for allowing myself to indulge in the sadness, for the selfishness of wondering what I would do, for the fear of worrying that it could happen to me, for the arrogance of thinking it couldn't. I hated myself for the relief that it wasn't me, knowing that I wouldn't be able to live through it and knowing that I wouldn't even try- and for the guilt of knowing I probably would never have to.

I hated myself most for the two emotions that I was left with when the tears had dried—the very two things she had reproached Dr. Green for— suffocating pity and the admiration that inevitably followed. Amy wanted neither of these things because they only served to make her super-human and separate her from the people and ordinary things in which she had found such joy. She wanted Dr. Green to stop treating her like a puzzle, something to be revered but ultimately solved. I wondered if someday after the years of hard work and training, I would do the same. I entered medical school to learn the science of disease, to master diagnostic challenges and learn to treat them. I wondered whether I was prepared for what she asked of her doctor, to accept that there was nothing to give but comfort and understanding. As I watched Amy rock back and forth, I realized why she came back here after all those consults. She didn't come for a diagnosis and certainly not for a cure; she didn't need a doctor, someone to run tests and scans. She came to be heard, and in the process, healed. All she wanted was a caregiver, someone to share and guide her through this experience. She wanted her physician, someone whom although she couldn't see, knew was there to listen.

THE DANCER AND THE GIRL IN ROOM 307

Chiao-Wen-Lan

307 號病房的舞者和女孩

Life is having the light movements
Through the blood streams
Air fills up the lungs

生命輕輕地舞動著
透過血液
空氣注滿了肺葉

Life is pushing forward
No matter what
Leukemia can't intrude this moment of dance
Moving forward without giving up any detail behind
Moving forward even it's just the finger tip
Pushing against
Using full body energy
Pulling out the full body energy

生命不斷地向前進
無論如何
血癌無法侵入這一刻的舞蹈
向前，不遺棄任何一點細節
向前，即使只是指尖
前進
用盡全身的力氣
釋放全身的力量

Arms going up
Going down
Keep trying to dance the pain away

向上
向下
用舞蹈來遺忘疼痛

Our bodies connect in warmth
A growing, increasing stream
A stream of movements,
Vibrating,
Resonating,
With the cells it passes by
The flow of energy activates
Our cells, tissues,
Fingers, Palms,
Hearts

我們沐浴在溫暖中
一股暖流逐漸形成
一連串的肢體動作
振動著
共鳴著
在這股暖流所經之處
它的力量活躍了
我們的細胞，組織
手指，手掌
和
心

And,
I become fully aware that
I am alive
You are alive
I am here
We Are Here
Together

此時
我突然明白了
我活著
你活著
我在這
我們在這
一起

2. Once a Stranger

THE PATIENT-PHYSICIAN RELATIONSHIP

Ahkillah Davis

Within the private enclosure of those walls we traversed the terrain of a life
Unfolding upon the feet of words iridescent with sound
The moment ephemeral–
Marked as history when pen was taken to page–
Transforming–
For I–
Once a stranger–
Now
A confidant
Partake of this exchange

eye contact

Jordan Cole

Her eyes were knowing, enormous on her small face
with no hair to frame it.
She was five years old.
Already, she'd had brain surgery, chemotherapy, countless infections, and been labeled as failing to thrive.
The medical team took blood pressure, pulses, scans, veins, and her strength.
Her body seemed not to belong to her.
But her eyes were her own.

His eyes were warm. He chuckled and joked.
He tried to smile, but could not.
Nor could he puff out his cheeks.
Myasthenia gravis prevented his facial muscles from working.
I knew I had to come in when I started choking on my steak, he told me.
He could not shut his eyes, either. And his left did not move at all.
They weren't under his control.
But his eyes were kind.

His eyes were fearful. It was Parkinson's, they told him.
No cure.
He was desolate, lost in solitude and hopelessness.
There's nothing you can do for me, is there, he said. It was not a question.
I held his hand. I saw his eyes. Would you like to speak to a chaplain, sir?
No, no, he protested. I talk to God every day. I'm ready to die.
But his eyes were afraid.

Her eyes were hopeful.
She wanted always to be compassionate, to remember
who she was,
And to ask why.
Sometimes she felt weighted with expectation, wondered how she had gotten here, and whether she was worth it.
She always decided she was.
The past sometimes called to her and reminded her to love.
Her eyes held on to truth.

PERSPECTIVE

Victoria YY Xu *Pencil, gouache paint, black ink with print carved into linoleum block*

THE PHYSICAL: A SESTINA

Mohini Dasari

I introduce myself and taste the quickening of my pulse
in my carefully chosen words. I hold my breath
and observe her emotion and affect. We are alive
today, which we can agree is something to smile
about, usually. I don't know if I will ever look at anyone's skin
without wondering about the stories that their blood

carries, coursing throughout their being. The diversity of blood
is measured in more ways than serotyping, I think to myself, as her pulse
multiplies into a heart rate in my head. I examine her pale skin,
her fingers laced motionless in her lap. "Take a deep breath
and then exhale, please." The cerebellar tests evoke a smile
from her, and I can see some amusement in her eyes, alive

with attention as she performs the tasks. I feel acutely alive
as I go through my checklist, and I start to visualize the blood
moving through her atria and ventricles. Her calm smile
broadens as I hold her arm to check her reflexes. Her carotid pulse
is palpable bilaterally, and as I listen for any abnormal breath
sounds I begin to wonder what her childhood was like. My skin

feels hot with shame for letting my mind wander. Skin
tells so much; we must read books and their covers. We are both alive
with questions. I wonder, when she was holding her breath,
what was she thinking of? I palpate her dorsalis pedis pulses, and feel blood
flowing dutifully there. All seems well. The simple joy of palpating a pulse,
strong and unmistakable, is unparalleled for a novice student. My smile

cannot be hidden, and I am well aware of my innocence: my smile
is the thrill of a child who beholds a glistening gem: medicine. Skin,
bone, muscle, viscera; it is all part of the oyster for me, still. And the pulse
is what holds this mystery, the body, together. To be alive
is the most vital sign. I examine her eyes, her blood
flowing in intricate lines across her retina like red roads on a map. Her breath

rate slows down, and I realize she is sighing. I hold my breath,
reactively, waiting for her to speak. She does not. I venture a small smile,
and ask, "Is everything okay?" I am about to measure her blood
pressure, but decide to put the cuff down instead. The skin
on her face suddenly appears more wrinkled to me. Her eyes are alive
with feelings to express, but her mouth does not open. My pulse

fuses with my breath, and I feel suspended on the skin
of this intimate moment. I do not smile, but I am alive
with a curiosity in my blood that gives medicine its meaningful pulse.

THE TREE

Thomas Hart Hull

I receive my white coat surrounded by smiles
I don't see science I see love
under God above, the real white coat
the dove
and years to come maybe will I look back on what I wrote
instead of beyond
when the mother asks will her son recover
how will you respond
will you hover
should you tell her that fear is ok
what can you impart..
that it is natural to shy away
for the flames the same which draws us into the fray
propels us into the dark with clear eyes and a full heart
why even these embers would still burn remains unknown
is my forest mine alone..
no, you have roots still yet to be grown
through fire and destruction
the tree will be born again
much will be said
growth with experience and instruction
the green will turn to red
the orange yellow back to green
a new man, a doctor, for them
paradigm of serene
a search for meaning unseen
but do you really need reasons
for these intrahuman seasons..
horses sprint the open fields not trying to please Him
they run because they love to
it is not duty
the world should thus exist for you
to satisfy the desire of beauty
so I will turn to her and say
if it were my mother and me
remember him also as a time of day
a mood or thought, a touch of hand
a setting sun over shimmering sea
an evergreen tree atop the highest peak
sunlight's warmth on your cheek
your feet beneath the sand
moments holding him in your chair
that spot he forever occupies
transcending time and space
you rocked him gently stroked his hair
cherish not just his face
rather, his glow in your eyes
blue diamonds so rare
sparkling with grace
I don't have the answers, can only feel what is true
but the qualia is a precious clue
that roots from conception to birth
grow stronger with our time here on earth
one life as two
two lives as one
he still lives within you
just as your love for Him
will never be gone

STORYTELLERS

Ting Gou

1.
You've heard the stories of buildings being burnt down
for insurance money or simply for fun,

arson being a pastime cheaper than a movie ticket
or a bottle of tequila.

So when you saw the cars double-parked down your street,
heard the shrieking from teenagers who turned

your neighbor's foreclosed home into a frat house,
glass necks and mouths of beer bottles floating

like jetsam among the tall grass,
you thought, "It could be worse."

2.
After three visits, I've become familiar
with your storytelling. First, the display
of something terrible, then the dismissal,
like a magician who saws the smiling assistant in half,

only to reveal she was never in harm's way.
We see what we want to see.

After twenty years of sterile clinics,
weekly regimens of drugs with alien names—

methotrexate, metformin, rituximab—
you focus our conversations on small gestures,

how your husband counts medicine
for your pillbox every Sunday

so you don't have to, how he rearranged
the furniture for you. Even the robbers, you say,

who pilfer your neighbor's desecrated house
leave the main structure alone.

3.
My classmate and I have an actual assignment:
"Ask your patient about stigma and illness."

What does your indifference mean?
we write in our reflective essays,

while what I really want to know is,
What does it take to dismantle a house?

A tear in the chain-linked fence
that lets me sneak in to poke behind your façade

with a flashlight? Or does the veneer,
like paint, peel off by itself,

muddying the clean layers,
one story running into another,

you telling us about helplessly watching
outsiders tear your neighbor's yard to shreds,

all while sipping rosehip tea
and scratching your dog's ear?

4.
I want to believe in the silences between us.
I want to believe that, after the trauma of diagnosis,

the shock of having to cope,
the reorganization of a life,

there is stillness.
The stories you tell me, embellished or not,

take root in my mind like wild grass reclaiming the lawn,
for better or worse, after destruction. After the last stranger,

having gotten what he came for, drives away,
leaving a new landscape.

3. Test of Endurance

WHAT IF

Peter Caldwell

I am trapped in a giant sterile space suit,
Overheated and underutilized,
Watching a knee replacement.

I must emphasize *watching,*
As the attending has not acknowledged me,
Much less included me in the surgery.

As I stand there, wishing for something to do,
My mind wanders and I reflect
On absurd hypothetical situations.

What if….
I became dizzy and fell over,
Crashing through the sterile field,
Pulling my spaceman brethren down with me.

What if….
I suddenly grabbed the patient's foot,
And used it like a microphone
As I sang a Justin Bieber song.

What if….
After an especially nice stitch,
I gave the attending
A victorious pat on his butt.

What if….
I slowly and casually
Moonwalked out of the room
Without saying a word.

"…so like I said Student Doctor,
hold here and DON'T pull too hard.
It's fragile. Got that?"

My hand is on a retractor,
Holding back a delicate structure.
Oh, no. What am I retracting?

Five minutes of stillness passes,
And I still have no idea what I am holding back.
I wonder, what's the worst that could happen?
What if….

TRUE MEDICAL STORIES

Daniel Eison

(Presented with apologies to Tim O'Brien, il miglior fabbro, whose magnificent "How to Tell a True War Story" is the inspiration for my piece.)

Medicine is full of stories, but almost none of them are true. A true medical story is easy to pick out because it has no purpose. The stories that are bandied about at the bar after work, recounted with hyperbolic sensationalism that is just barely covered by a wry *weltschmerz*, are not true. They start with phrases like "Oh, I had this one patient..." and "So, get this...." The teller sighs and sizes up his listeners before divulging the latest indignity heaped upon him by medical happenstance. The universe had the temerity to present something so outrageous to me—a doctor! And all present, doctors themselves, shake their heads or laugh knowingly, outwardly sympathizing and inwardly rifling through their own Rolodex of escapades, sniffing for a follow-up. Inevitably one is found, and the conch shell passes on to the next weary hero with a light in his eyes and a dramatic grimace on his face. He takes a sip of beer before throwing his own tale on the growing heap, hoping to top the last with his account of non-compliance or "fascinoma" or, best of all, personal chagrin. And all the others nod and sniff empathically. And sip more beer.

These stories are told as collective catharsis, to build *esprit de corps* in the face of the implacable foe—the patients—and as such, these stories are not true. They are the hero-boasts told in the mead hall, of swimming races lost and won or blood feuds pursued unto ruin, the brazen hubris of yore tempered by the custom of our era into sardonic world-weariness. Each yarn supposes in its muffled grandiosity that it is better than all the others. They boast subtly of survival despite the odds, of having the courage to continue in the face of insurmountable paperwork and bureaucracy and dangerously self-educated patients who declare autonomy with a constitution cribbed from WebMD. These stories are about the struggle of us and them, and they aren't true. Not really.

On the Labor and Delivery floor one night, a woman came into triage because she had started having contractions at 37 weeks. (Can you already tell that this is not going to be a true story? You will soon enough.) She was there with her husband, and to merely say that they were French would be to do an injustice to the notion. Both were stamped with that unmistakably Gallic set of features that would make them stereotypes if I had not actually met them in the flesh. He wore a beret over tumultuous gray hair. She had warts and skin tags sprinkled across her angular face and a spray of wispy locks drawn up in a loose bun. They were the innkeeping couple from "Les Misérables" come to life. (Do you see? This can't be a true story. Not with characters like that. Of course it really happened, I really met them, they aren't a fiction; but that doesn't make the story any more true.)

Pursuant to examination by the medical student (me), the intern, and the resident, the woman was admitted. Past medical history? None. (Remember that—it's important to the punch line.) Following a protracted and unproductive labor, she was sped to the OR for a Cesarean section, which she decided to complicate with significant postpartum hemorrhage. At M&M the following week, much would be made of the timing of the activation of massive transfusion protocol. Also at that conference is when I would learn the coda to the tale: as the Thénardiers were leaving the hospital a few days later (Oh, of

course she lived—this story isn't about *that*!), they pulled out a sheaf of paperwork—all in French, naturally—that explained her thrombophilia and Factor V Leiden disorders which predispose her to excessive bleeding (punch line!). The attending who announced this at M&M called her a rude, though childish rather than obscene, epithet that I can't quite remember. She didn't think to mention it before, when we had asked her about any medical problems she might have? Good Lord! See what we have to put up with here?

But there isn't really anything true about that story. It's just another version of the same story that keeps being told from doctor to doctor and back again, more grist for the ever-churning mill that makes our daily bread of hard-fought endurance. Plus, it has a punch line and maybe even a moral. No true story has either. Jokes do, fables do; true medical stories do not. Like O'Brien's true war stories, true medical stories do not generalize, do not indulge in abstraction or analysis.

Here's another story. It really happened to me. I had run down to the blood bank to deliver a pink-topped tube for type and screen. It might even have been for the French woman, for all I can remember. (After all, this story takes place in the same fantasyland as the first, so if the mother in that brushes up against the crone in this, who can complain? They're just aspects of the same archetype anyway.) I was returning to L&D, suffused with the righteous quicksilver of a med student on a mission, and jogged onto the crowded elevator, fumbling with phone and pocket manual and index-card checklists. In the middle of the packed car, an island unto herself surrounded by the waters of courtesy, was a little old lady with a big red walker. As I thumbed through my to-do list, she looked up at me and asked with a knowing smile, "Are you one of those new July people?" Knowing she meant the new interns, I smiled sweetly back and replied, "Oh, no, I'm just a medical student." As the doors opened and she clunked her walker forward, she chuckled and reached up to pat me on the shoulder. "Oh," she said, "you're even less than that!" and hobbled off the elevator.

Isn't it a nice story? It's a self-satisfied story that continues the grand tradition of taking the piss out of a medical student, humbling the fool who's already in motley. It's the kind of vignette you might see on *Scrubs*. It's entertainment: I knew it as it was happening and every time I tell it I stretch it out a little more, wallow in its perfect cadence, relish the laugh it never fails to elicit. From the moment I was left standing in the elevator, though, I knew it wasn't a true medical story.

A true medical story must be told for no other reason than that it happened. Any heroes or morals or punch lines give them too much *raison d'etre*. Even symbolism and metaphor is inappropriate in such a story. Wallowing in the language would be inappropriate, as would glorying in the grim amorality of a story about disease and death. Affectation would kill it. You fumble for something to fill the taut silence once it's over. You tell it because it happened and that's enough, that's why.

It was late afternoon on my third day of L&D. I don't know who the patient was or even why she was getting C-sectioned, only that one of the residents told me to scrub in quickly. Emergency Cesareans move so fast. I don't think I had much time to register what was happening, because all I remember is the baby being pulled from the wound blue and floppy. We ran around, all of us, and screamed for NICU nurses and a pediatrician. The room was packed with people in blue, most clustering around the warmer, watching a nervous doctor intubate the newborn. The obstetrician calmly remained at the table, presiding over the mother's gaping belly, quietly instructing the resident imbricating the cleft-open uterus. Behind the drape I could hear the anesthesiologist explaining in measured tones that sometimes babies have a bit of trouble breathing when they

first come out and that they were taking care of her and that she would be fine, that they were going to take her to intensive care now. I heard him ask the father to please sit down, behind the curtain, for safety. I saw a Foley bag full of blood and heard the resident and attending agree that it had been that way since the beginning. I saw the look one pediatrician gave the other from across the room.

When they'd spirited baby away in a glove box and stitched up mom, the drape came down. Behind the curtain was a chilling tableau, a dumb show image I can't forget. The father, a silent pile slumped on a stool, looking past his wife. She lay cruciform on the table, also staring at nothing. And that was what really got me, you know? The look on her face. Dead-eyed and staring past everything. I'd seen a handful of patients in real agonizing pain, but I'd never seen pain like that before. I hope I never see it again.

The nurse who'd shouted at me earlier to run and get someone from NICU asked if I could get the patient some socks from the closet. I knew I'd seen them earlier, but when I went to the shelves I couldn't find them for the life of me. The crowds had left and the OR was hushed as I stood and scoured the supplies for the socks I knew were there. I couldn't find them. The nurse, behind me, directed my gaze: down, down more, left, no, you passed them, right there... no, there! I looked back, bewildered, and then spotted them as I turned to the shelf again. The nurse laughed, kindly, as I handed them over. They'd been right in front of me. I smiled, but for the first time in three long days I felt really tired.

"Thank you for all your help," the nurse added. I shrugged. "Thank you," I replied, not really knowing what else to say. I plodded into the NICU, leaving my mask around my neck, as I might self-importantly do to impress the civilians in the elevator on another day. That day, the mask was my passport, and nobody questioned my presence among the incubators. I scanned the ranks of infants and found the one I was looking for, no longer blue, weakly squirming.

I left, and didn't go see the mother. I thought then about significance and symbolism, and how the events would fit in the narrative of my medical school story. See, true medical stories are full of pompous idiots who wonder about significance and ascribe deeper meaning to the bald events. But true medical stories don't have significance, and that's how you know they're true. You don't ask why they happened and they don't explain. They happened, and when the telling is done, they shrug and wander off.

COLOR OF YOUR COAT

Ashley Landicho

he dreams
not by the color
of his coat
but the character
of his intention

immaculate white
unveils his virginity
soiled and ruffled smells
of the exchange
of war-time veterans

he is a dot.
a speckle barely breathing
on a pecking order of necessity
but inopportunity for some

higher branches
see horizontal neighbors
blind to the depth
of worthy roots

purity in this field
does not remove
the wrinkles in others

no time.
a vindicated alibi
too often plead to those
with eyes of scrutiny

patience is the namesake
of our purpose
yet its medicinal forces
are seldom exploited

honorably discharge
your polluted uniform
that once reflected
light back to those who
cared to look

grow from the masses
that buttress self-security
replenish hypocrisy with hippocracy
of the oath to do no harm
especially to those wearing
the same badge

nurse

Rudy Clark

Handmaid, mother, whore, priest, sinner, saint
Where do I fit, where do I fall.
Take off the red stiletto heals
Take off the wings and halo
to play in the dirt and with the slime.
Describe it, define it, label it to send,
But will I hold in the
Beeps and leaps and moans of
the chains that rattle to tie and bind you down.
How could I?
Why should I?
Play, act, repeat.
Act, play, repeat.
Do what they say, do what they scribe,
did I do it right?
He, she, they will tell me in every way.
When do I stay?
When do you go?
I am right, I am wrong.
I try to belong.
I am Just.

BRAVE NEW MEDICINE

Sally Azer

Imagined, still unforetold, are the possibilities
Encompassed in a white coat,
For with a firm knock before entering
Opens doors to the ensuing journey.

Formulas fail to positively predict the value of this opportunity.
For from charts, we set sail toward uncharted territory.
Unknown until explored
We boldly proceed
Cautious of the risks,
Intelligibly equipped with caffeine.

Soon our findings form a differential
Between what once was and what may be.
Alleviating factors discerned amid pain
We learn to forget transient complaints
Chiefly for the oath we keep in reverence
Will find its worth sustained.

A dose of reality can be intoxicating,
In quantities not taught in pharmacology
Nor prescribed per patient ID.
We happen upon medicine by choice and by chance,
And it treats us as we let it.
Side effects are felt in adversity and in triumph,
In continual inching through this valley of death,
We come to find healing in its end.

The question stands,
After all exam bubbles have been filled
Will those cold hands remain to poke and probe,
Numbed by the years of bearing a yoke?

No matter the depth an ophthalmoscope offers,
Eye level grants us the most sobering sight,
For there we see
We have been clothed in hospital gowns
All the while.

To keep an art from disintegrating into a sterile field
The sharp or dull quality of our attentiveness
May be the factor to favor the fate of health,
For presently we write history
So cease the moments as they come
And let history document itself

CHASING THE LEARNING HIGH: CONFESSIONS OF A CLINIC ADDICT

Will Jaffee

Based on what's left of my neuroanatomical knowledge from two years ago, as well as that from undergraduate neuroscience labs involving some happy, lever-pushing rats, if I were to guess about my brain state that morning, I'd say it looked similar to someone who'd just had an orgasm or gotten high on some street drug. It was only 10 am, and my mesolimbic reward pathway was lit up like the eyes of a puppy waiting for her food, my dopamine stores exocytosed like water-bombs into the cleft, and I felt great. Why? I'd just punctured an easy-to-see vein with a hypodermic needle.

So, why all the fireworks for such a mundane task? After all, with the specialization of the medical field, those with half of my years of higher education collect blood this way every day. Heck, while I'm on the self-reassurance kick, I've cut people open, sewn people up, injected, biopsied, DRE'd, and done other invasive procedures, yet somehow never actually done the mundane task of drawing blood or starting an IV. Why bother? The medical assistants and nurses do that stuff anyway, right? And I'd do it at some point, right?

Maybe. Medical education is a bizarre beast that, clinically, hasn't changed all that much since its own (reorganized) birth following the Flexner Report in the early 20th century. Creating future doctors via the "see one, do one, teach one" mantra actually works surprisingly well for small procedures (cyst removals, injections, etc.), provided we actually *do* more than one. But guess what: there's no *definite* chance to *do* anything, that is, if you don't speak up. So after I got to know a 45 year old buff male patient who needed routine blood work, I decided to take the bull by the horns and lied (a little!) to the medical assistant D.

"Hey, D, do you mind giving me a hand getting this guy's blood?"

"Sure. You done it before?"

"Yeah... like once [on an expensive mannequin arm]. But this guy's got good veins."

D didn't flinch and begun grabbing the necessary paperwork, collection tubes, and cotton balls with alcohol, etc. As I cleaned off his vein, I held up the needle to make sure I was angling it bevel-up, got some traction, and popped it in. Boom! Blood in the line. "Fake it 'til you make it" had never swiftly borne such dopamine-rich fruit in my life.

Even though I'm starting to feel more and more confident with some lidocaine, a scalpel, and a cautery device, the "routine venipuncture" was enough to get my adrenals pumping. Why? I hadn't yet done *any* venipuncture (hello, cortisol release!), but also because I'm becoming addicted to the learning high. Indeed, it was a true endogenous opioid buffet this morning. For almost my entire academic career, I, like everyone else, have enjoyed that critical "aha!" light bulb moment of finally understanding some *concept*. But my goodness, the clinic learning high is at least as good, in part because it's new every time. As soon as I walked out of the 45 year old's room and into the next, I was delighted to meet a 53 year old man who said he thought he was due to have a med student clumsily piece together the plastic hub, hypodermic needle, and vacuum tubes, and then forget to remove the tourniquet. Final product? Four clean vials of blood, a happy patient, a few beads of sweat on my bald head, and a medical assistant who had less work to do.

And so the addiction was strengthened, and the withdrawal symptoms followed. Sitting on the couch at home after leaving at 7:15am and getting home at 7:30pm, I feel guilty for not continuing to study and tired but excited to return to clinic. The *conceptual* "aha!" rewards still happen and always will. But earning the trust of your attending by properly and safely completing some novel, albeit small, procedure is at least as satisfying. Happy patients and happy attendings make happy med students, reinforcing our motivation to keep learning, and keep chasing that learning buzz. So as my current attending said recently, "the better you get as a student, the higher I set the bar" and it's just this type of cyclic learning that I'm growing to love in an entirely new way. Like any form of dependence or addiction, there isn't really an end point of ultimate satisfaction. There is, however, always another procedure to learn, and another pathway to review. And, of course, another pot of coffee to brew.

4. Healthcare: The Big Picture

TRIAGE

Alexander Andrews

I'm introducing the needle into the limbus of Ms. Henderson's one good eye. She squirms on the exam table.

"Hold still," I say as I withdraw a little and redirect. "Bayes' theorem tells me that this is the best thing for your sight. I'll draw you a chart when we're done."

"I've never met a Dr. Bayes before," she replies cautiously. The office light buzzes above us. I let the subject hang, but she continues. "Doctor, all I want is to live long enough to see my good-for-nothing son turn a new leaf. I want to see him make something of himself. A minor leaguer, or heck, a relief pitcher for the Cubs. I don't know. A violin player in the Chicago Symphony."

She shudders. Her head rocks violently and for the safety of all parties I let go of the needle, whose hilt glints as she sits up and levels her gaze at me. The single eye visible in her round and stolid face is a fake and the other is covered by a plastic plunger. "I know you can help me, doctor."

Just then, my phone buzzes. With one hand I pull it out of my pocket and with the other I pat Ms. Henderson on the meat of the shoulder. "That's why I'm in the business," I coo, "to give sons more time to impress their mothers." She lies down and looks up at the ceiling. I look down at my phone.

This is a strange time for Ronny to be calling.

Just a few months ago, Ronny had fallen off the junk wagon and required police removal from the Buckingham Fountain for splashing tourists. For years he'd been on and off the stuff, and in bad times became a plain terrorist, a hostile citizen on the loose in a city too small to hide him. I recruited him for my little operation on the condition that he clean up. I thought he would be an asset, knowing the product we move, but things had been up and down.

I excuse myself to the hallway and Ms. Henderson nods her assent. I flash a hand sign to Nurse Paul–*pull a needle for me, will you?*–and then I pick up the call and bark at Ronny in private.

"What?"

"We're screwed," I hear on the other end. "It's that Gimlet, man, you shoulda never hired that Gimlet."

I run a shaky hand through my hair. Don't yell here.

"We were at the warehouse and she ambushed me," Ronny continues. "She made off with part of the stash and then narc'ed on the rest. I tried to stop her, but she got away. I think the cops are coming."

Ronny babbles. I head past reception and make for the parking lot. Fall's death rattles have shaken the last few leaves from the trees, and now the snow is speckled with grime like a tarry lung.

This is the place to talk. "Do you realize what's on the line here? I thought you and me could

get into business." All I get from Ronny is heavy breathing, a high pitched whine. "Tie it down, Ronny. Tie down the stash and get out of there. Meet me at the safe house."

Then there's a crash and the call drops. It could have easily been the steel door of our warehouse crumpled in the fist of Chicago's finest.

I kick hard at the clotted snow on the wheel well of my junker Chevy. If Ronny's smart, he's running. But if he's running and drops his phone, the cops have something traceable. I climb in and turn the key in the ignition.

As the engine churns, I try him again. Voicemail.

It occurs to me that Ronny has never appreciated the gravity of our situation, that he's never peered into the pits of legal hell reserved for white collar criminals such as ourselves. The operation was never meant to be complicated: our "patients" see our "providers" to get their "scripts," the pharmacists on payroll fill the scripts, then we let the "patients" skim a little off the top when they drop their supply off at the warehouse for packing and distributing to the runners.

Simple.

I must have given him too much responsibility.

My head's imploding as I speed through the sleepy suburb where my partners relocated years ago. Why did we hire Gimlet again? Was it really the cops at the warehouse? Was Ronny making his way to the safe house? What about poor Ms. Henderson? Had Nurse Paul understood the message?

An uninviting wind blows in through the passenger window that won't roll up. My car shows signs of its age: a window stuck at half-mast since the crankshaft rusted, a cracked ochre dashboard the color and texture of a smoker's nail beds, and a floor mat that sometimes interferes with braking. It's a peculiar set of risk factors.

The wind bites my cheek like neuralgia. It licks at the top cover of the manuscript piled on the passenger seat.

My manuscript. Oh, if everything falls apart, at least there's that.

It's a project I started in medical school, a self-help type book that I wrote when I realized that I was meant to touch people. Each chapter starts with an inspiring quote bubbling up out of a glossy picture of me posing in a white coat, holding my stethoscope accusingly. Chapter One is ***Our fathers don't fashion our bootstraps.*** It's all about mastering your destiny and reclaiming your life.

The chapters are short and are meant to be read one at a time, once a day. I've finished a total of about 2,000, one for each day of medical school and for the duration of the average residency, no weekends. When I find a publisher, I plan to put out an epilogue set for brain surgeons.

I try Ronny again and reach his voicemail.

The phone thuds on the floor of the car. The wind picks up as I accelerate onto I-90. It lifts a few hundred pages off the top of my manuscript, and before I can do a thing, it sucks them up and out into the late morning traffic.

Glossies of my face rain down on unsuspecting drivers in the breaking blue morning, and some settle quite far away. ***Keep focused*** falls on a community college quad a few blocks away. A student picks it up on his morning run and brings it home to frame above the fireplace because he finds my facial expression frankly hilarious. ***Center yourself*** blows into the open window of a school bus, and a little first grader stuffs it in her backpack. She spends the next several nights convinced that my visage haunts her closet at night. ***Stuck in a rut? You are your earth mover*** settles on the shady porch of a house where an elderly couple, fifty years together, argues

viciously. At this strange intrusion into their personal lives, the tension breaks. They share a laugh and retire to bed for the best make-up sex of their lives.

Having had enough of this god awful day, I pull up to the median and flick on my hazard lights.

In the end, you're only human is plastered to the pedestrian walk above my head. Although there's never a good time to walk a Chicago highway, my manuscript is scattered in clumps and I think I can recover most of it. Preparing to run, I felt a buzz at my hip. It's Nurse Paul on the pager–Lost Ms. Henderson.

"Lost?" "Lost" as in gone for good, or "lost" as in simply wandered off? My phone is back in the car. My manuscript, that itinerant caravan blown out the car window, eddies underfoot of the traffic.

Then a terrible vision plays out before my eyes: it's of the poor Henderson boy. He's playing lonely violin to an empty auditorium. None are there listening except the night janitors Febreze-ing the seats. I'm there, off-stage, facing a giant set of gold-leafed doors, getting ready to break the sorry news to the Henderson boy that his mother was one of Bayes' unlucky one percent.

Note from the Author: Through the character of a doctor with dubious intentions, this story explores the sometimes scattered nature of our lives in medical school as well as the unintended effect we have on the people around us. This is a work of fiction. Any resemblances to persons living or dead are purely coincidental.

THE RIGHT

Boris Gilyadov

A man is walking down the street
and suddenly he gets a tearing chest pain.

A passerby, who happens to be an EMT,
yells out right away:

"Stop!

You have the right to remain healthy—
(I mean, the right to good health)
—but in this case you…

have the right to a physician.
Anything you say can and will be used
to assess your condition
and help determine the right prescriptions,
the right management,
and the right medical decisions.

If you can't afford a physician,
then one will be provided for you
by a politician
who will use
his powerful position
to realize his personal ambitions.

And apparently,
you have the right to be lied to
for years pass,
yet the problems continue to grow
and spiral
like fresh grass
emerging out of cold snow.

And you:
You, my friend,
have the right to know
that you have rights.
And it seems
that's about it."

BRIDGING THE GAP

Isaac Siemens

It's a cold, gray November afternoon, and I'm sitting in the back of a van that serves as a moveable clinic for vulnerable people in Halifax, Nova Scotia. I'm listening to the nurse and the needle exchange worker, who are copiloting the van, joke about who has a better track record for planning their route through Dartmouth, the sister city to Halifax that lives across the harbor.

We are creeping across the MacDonald Bridge at rush hour. From this vantage point, both sides of the harbor spread out with the foggy mystery of the ocean between them. The veneer of the Halifax business core, with its casino and waterfront condos, looks over with a hollow expression at the more industrial and rugged Dartmouth side. A huge burning flame on the top of a chimney stack at the oil refinery lights up the misty air.

I am working with Mobile Outreach Street Health (or MOSH as the license plate reads) as an elective that is part of my medical education at Dalhousie University. MOSH is an offshoot of the North End Community Health Center (NECHC), an interdisciplinary clinic on Gottingen St. in a community plagued by socioeconomic hardship. We are heading out to check in on some of the regulars who use the outreach service for multifarious reasons: needle exchange, first aid, and medication delivery, to name a few.

On this trip, we are joined by an employee from Mainline, a needle exchange program. MOSH has teamed up with Mainline because of an overlap in the populations they serve. Most of the people we see are vulnerable to the point where they have trouble using more mainstream healthcare, such as visiting emergency departments, hospitals and family medicine clinics. These people are vulnerable for many reasons: addiction, poverty, mental health and adverse housing situations are some of the big ones. Try staying in a hospital for a few days when you start going into opiate withdrawal after eight hours. I hear it's hard.

MOSH, the NECHC and Mainline, along with public housing, multiple shelters and other services for addiction and poverty are located in the Gottingen St. area in the north end of Halifax. However, as property values have been climbing in the area, the populations that use these services are being pushed out. This is leading to a situation where people are living too far away to use the services that were created to help them.

This is where MOSH comes in. MOSH is an interface between established health services in Halifax and the populations they serve. MOSH sees people where they are and keeps in touch, even as they move around the city.

After crossing the bridge, we stop at a pharmacy so the nurse can pick up some antibiotics. The first person on our list has a huge abscess spreading under the skin on her arm and crossing over her elbow.

She is an IV drug user and is staying on the couch of another person who is seen regularly by outreach. The nurse and I are invited in. The abscess is quite angry looking. The patient's skin is red, radiating heat, and she can barely bend her elbow. I'm struck by how far along her infection is and how most of the patients I see in the hospitals would have been treated long before this stage.

The nurse offers to drain the abscess, and our patient says yes. We complete the procedure on top of the dishwasher in the kitchen. Her roommate stares on in stoned disbelief as a huge amount of putrid fluid spills out onto the absorbent pad we had laid down. Our patient is thankful for the relief, and we bandage her arm and give her antibiotics. She takes two right away without instruction; this is clearly not her first course of treatment.

Back in the van I think about the absurd contrast between what I just saw and my usual elective experiences in large teaching hospitals with white hallways and hand sanitizer on every surface. As we drive through the dark streets I see boarded-up grocery stores and empty, dark parks. The Mainline employee turns around in his seat and asks me "Is this the type of medicine you want to practice?"

I'm not sure how I answered but I have been thinking about this question ever since. What is the type of medicine he was referring to? For me, the experience of engaging in the health of a community is common to all medicine. These populations I am working with and their struggles are encountered in all practices. Maybe what he was getting at is something more along the lines of "Will you learn from this experience and incorporate it into how you practice medicine, or will you ignore the problems you see and thus make them all worse?"

The experience I am having, working at the NECHC and with MOSH, is not something that all medical students experience. I had to seek it out. The curriculum includes topics like addiction in short, discrete lectures in a university lecture hall and relegates them to societal issues that must unfortunately be dealt with, sometimes by physicians. However, when you go out in the community and seek out patients who are besieged by poverty, addiction and mental health issues and who live transiently, you begin to see that these issues are the core barriers to health on a population level. The scale of this problem transcends the divisions between medical specialties.

At the end of our route, we drive across the now sparsely trafficked bridge to the Halifax side. We have done a lot tonight but with this being my first exposure to this type of health care, I am feeling overwhelmed by the gravity of the problems our city is facing. I am starting to see MOSH as a bridge between the sanitized veneer of the health care system and the rugged reality of socioeconomic adversity.

It is easy to point out the benefit of this relationship for the vulnerable populations in Halifax, but what might be more obscured is how this relationship is reciprocal. Just as we drove back across the bridge at the end of the shift, the lessons learned in reaching out to vulnerable populations needs to be brought back to healthcare workers in a more meaningful way. We need to find a way to make the halls of the healthcare system more welcoming to the sickest members of our society, even if that means getting rid of some of our hand sanitizers.

The only way I can think of to encourage a broader, more inclusive practice of medicine is through stories like this one. It is through shared experience that we can change our way of thinking, and storytelling is the fundamental way that we can accomplish this. When we tell each other stories, we engage people and challenge them to share the experience of another for a brief period. It is through stories that empathy can be brought out.

SHATTERING THE GLASS FLOOR

Warren Yamashita

Acrylic on canvas

LEAKY PIPES

Melissa McCoy

Drip.

Drip.

Drip.

Sweat poured like a river out of my pores, streaming down my back as I tugged at the giant tumor with my trembling hands. I held the soaking monster out of view of the surgeon as he meticulously tied one-handed knots around the neck-vessels threatening to burst.

Drip.

Drip.

The patient's blood puddled on the stained floor, swirling into a tributary on its slow journey toward the drain four feet away.

Drip.

Drip.

The mold-encrusted air-conditioner gasped, desperately attempting to expel air. A three-inch spider scuttled past. It sank in that I was far away from my pristinely sterilized, disposable-everything, rigorously documented surgical rotation in a world-class teaching hospital.

I focused on this mother of six, with her soft dark eyes, wisps of gray starting to appear in her tightly braided hair. I held her hands before the anesthesia took hold, and remembered how rough and strong they were, hands that told a story of harvesting manioc and groundnuts. I needed her to be strong right now.

More blood dripped.

Her massive tumor, a surgical "zebra," was caused by iodine deficiency (a rarity in my own country). "How ironic," I thought, "in Sub-Saharan Africa-land of the zebras." I had to remember she was one of the fortunate ones with the meager funds to receive treatment. As I placed a drain and sutured the gaping incision back together, I imagined sewing the broken pieces of her life back together, in this drippy hospital, part of a gushing, broken system.

Drip.

Drip.

Drip.

The bleeding stopped as I applied pressure to the dressing. "All bleeding stops eventually," the detestable surgical mantra chimed in my head.

I walked home, still dripping in sweat, thirsty and exhausted. I was still not accustomed to the baking sun of the dry season of the southern Sahel. A crowd gathered ahead of me on the road. A broken pipe jetted water into the air. The pipes here are practically constructed for failure. Brittle plastic pipes which, beneath the dirt road, are exposed by erosion from rainfall. With time, passing vehicles inevitably rupture the pipes, leaving all those downstream affected.

Precious water snaked its way toward my host family's little home at the bottom of the hill. Where does the blame lie in a cracked community water main? Who would pay for this damage and the strain it caused? Surely working through this together would be more useful than making accusations, as was now happening. For now, assigning blame was a purely human response in the face of stress. The exasperated crowd looked on with voices escalating and fingers pointing.

The next morning on my walk back up the hill, the water still flowed, my sweat still dripped, and my mind still brimmed with questions. How was my dear patient recovering? Would the 54-year-old with charming crow's feet and the soft, French-speaking voice I had listened to so

attentively still remember me? When I arrived, I glanced to her bed. She was nowhere to be found. Odd. My heart pounded. Where had she been transferred?

A vital pipe had burst.

She had died in the night.

The foreign surgeon tensely explained to me he was sure the nurses had been negligent. The nurses found her after the vessel in her neck had ruptured. They desperately grabbed sponges, removed the drain to divert the flow away from her airway, and did the best they could with what they had. It was too late.

Had the nurses been negligent? Perhaps they would tell a different story of poorly written job descriptions, inadequate training, and corruption that had led to missing paychecks for the last five months. This system was leaking in so many places; it was practically constructed for failure.

Drip.

Drip.

Tears streamed onto my green surgical scrubs. My heart threatened to burst, pounding so hard I was sure it would be overheard. Overwhelmed, I sank into an empty rust-covered wheelchair in the cluttered corridor, sobbing. This scene would have played out so differently at home. Anger was palpable in the air around me.

On my way home, the crowd still surrounded the burst water main. Now using buckets and bottles to detain excess water, my neighbors made the most of their scarce resources to alleviate the issue. I wondered who was responsible. Maybe the manufacturing company was at fault for making such weak pipes. What about the driver who ran over the pipe? Maybe the leak was just another consequence of a government failing to invest in infrastructure for its citizens. How could my neighbors, women selling 10-cent bags of groundnuts for a living, solve all these problems?

Likewise, who was responsible for the tragic death of my humble patient? Was it the powerful surgeon, giving commands from the high ground? Was it the overworked nurses, trying to follow the post-op orders from below? Maybe the lack of functioning equipment was to blame. Looking closer, maybe it was the hospital itself, an essentially for-profit institution selling health as a commodity rather than a human right.

The desire to pinpoint blame is powerful and instinctive. Shifting culpability to those downstream makes life easier in the short term, but our ultimate challenge in healthcare is difficult, one that requires moving counter to the current. To ensure quality healthcare in all parts of the world, we must discern and address the core issues fueling the current problems. Though multifaceted, the roots of these networks of blame can be traced back upstream to power and privilege. Acknowledging a steep gradient of personal agency, we must recognize where the streams of privilege have historically flowed.

Drip.

Drip.

Drip.

Privilege and power do not easily trickle down. The memory of my humble patient has inspired me to charge upstream, alongside nurses and neighbors, in more authentic partnership. We must work toward more cohesive system, one that starts with the problems upstream, in order to stop the hemorrhaging downstream for the ultimate realization of a world with fewer leaky pipes.

SHAKEN

Preethi R. Raghu

At times like these
I feel the distinct urge
To grab the world with an embrace
And rock it to and fro in my arms

At times like these
I could wipe tears and blood
From those rightfully jaded souls
And ask them to keep faith

At times like these
I would grip the world tighter
The world may stab or shoot
But that risk I have to take

At times like these
The world comes together
Only to ebb and flow until
Mourning families fold away

At times like these
Inconvenient truths and dirty thoughts
Surface like blood onto tender skin
Holding a mirror to ourselves

Note from the Author: This poem was written shortly after media coverage of the school shooting in Newtown, CT. I was horrified by the increasing violence -- or increasing media awareness of violence -- in the area, especially with incidents on the East Coast such as the Newtown shooting and more recently the Boston Marathon bombing. It is during these fragile times when we are prone to withdraw from society and treat our neighbors with suspicion that we need to bravely turn outward and embrace society with our much-needed gestures of humanity. "Shaken" is a tribute to the transient togetherness and sense of community that inevitably follows tragedy.

5. Express Fear

DO THEY TEACH FEAR IN MEDICAL SCHOOL? CLINICAL ANECDOTES

Ajay Koti

Image: "Self Portrait with Dr. Arrieta," Francisco Goya, 1820

Room One

Wendy Smith* had thinning hair, penciled-in eyebrows, and a frame so thin that you could see, in painstaking detail, the bluish-grey veins underneath her pale skin. Cancer had taken so much from her that she almost didn't look human.

But the feeling in the room was extremely human. Fear. Palpable fear. Fear made all the more palpable because this was an aggressive, rare form of cancer. Fear made all the more palpable because she was only in her early thirties. Fear made all the more palpable because the cancer had been discovered during her postnatal care following the birth of her first child.

Motherhood… and chemotherapy.

It was hard not to detect a little desperation in her husband's voice as he kept asking about new, experimental treatments that he had read about in his own research. It is chilling to think that the notion of single fatherhood has undoubtedly crossed his mind.

Room Two

Susan James* was older and had already experienced breast cancer, which had recurred for the umpteenth time after numerous rounds of treatment. However, the tumor in her breast was not the reason for today's visit.

Today's visit was to tell her about the tumor in her bladder.

Her visage was blank, almost hollow. The word "surgery" snapped her out of her shock. Waving her hands, tears welling in her eyes, she said that she didn't want to hear about surgery; she didn't even want to think about it. She had been under the knife already, a half-dozen times, endured radiation and chemotherapy, and now she had to consider surgery to remove her bladder—it was just too much. Too much, at least for today. The doctor, wisely, pulled back, consoled Susan, and urged her to go home, be with family for the holidays, and maybe even take a vacation. Decide in the New Year. No rush.

Room Three

John Peters* was different. A veteran of cancer fights, with the scars to prove it, John appeared nonchalant about his medical condition, nodding along to some of the doctor's medical jargon and tossing out some of his own, a demonstration of the expertise he had accumulated in the course of his treatment. As we left the exam room, he casually asked for a syringe with some saline solution, so that he could flush out his own nephrostomy tube, which, he noted in a matter-of-fact way, had become clogged after bleeding from his kidney.

The difference in experience between these three patients was rather remarkable. Susan and John had both experienced the pain and agony of recurrent cancers, but as Susan faced a world that seemed to be collapsing, John exhibited the serenity of a monk as he cleared his tube and strolled to the check-out desk with apparent nonchalance. Meanwhile, Wendy was forced to confront the immense contradiction between her newfound family life and her deteriorating health.

Medical school is an immersive experience. As first-year medical students, we push ourselves to amass large volumes of information—obscure muscles in the hand, mRNA splicing processes, neural pathways—all to build a comprehensive theoretical basis for the diagnosis and treatment of disease. Then, I met these patients.

I suddenly understood that my basic science training was desperately incomplete. There was no deck of flashcards, no clever mnemonic to guide me. I found myself digging up skills which I had developed at a makeshift clinic in a dusty church basement in Philadelphia, long before medical school ever started—making an effort to get to know them as people, not just as patients, investigating their concerns and expectations, and acknowledging their priorities. This was a time when I knew nothing about the medical sciences—whatever limited skills I had were restricted to the humanistic domain. They actually seemed to be enough at the time.

They even seemed to help these three patients. Wendy needed to be seen as a mother, not just as a cancer patient. Susan needed time and space and someone to hold her hand. John just needed a saline syringe—and respect for his strong sense of autonomy. Each of these patients was there for an office visit—there were no procedures, no prescriptions, and no extensive exams. But they left their exam rooms with a sense of peace in their faces—an expression that was not present earlier. Their cancers did not physically improve during their office visits that day. But their fear did.

A STORY

Peter Capucilli

An 80-year-old gentleman, who had lived a good life, visited his family physician at the order of his two daughters to discuss general fatigue that had become troubling over several months. The man mentioned, with some concern, that despite upholding a healthy diet as often as possible, he had unintentionally lost 15 pounds from his normal weight within the last month alone. Though he did not mind the extra weight off his figure, he was puzzled by the unexpected change. In recounting his story to the physician, the man realized that, in addition to the weight loss, he had also been experiencing difficulty breathing during his daily morning walks in the woods by his home and so proceeded to recount this too to the doctor. The doctor, who had begun to take notes into a manila chart, was quiet while the man spoke. When they were done, the doctor turned to his white coat, the shining armor, now tarnished by years of use for protection on the hospital battlefield. From deep in the side pocket he pulled his prescription pad and handed a well-scribbled document to the man. "I'd like you to have an x-ray at the hospital in the city, as soon as possible. We will proceed from there."

At the hospital, the man sat alone in a small examination room, waiting for the results of the x-ray he had just undergone. A knock on the door preceded the entrance of a tall doctor dressed in an equally tarnished white coat as that of the first doctor. In addition, a young apprentice,

whose white coat was less tarnished and shorter in length than that of the elder doctor, followed into the room. The physician spoke, "We believe you have cancer of the lung. This type of cancer has not ever been cured in the past, and there is a great chance that the cancer has spread to other areas of your body. We want to assure you that we will be looking for any cancers you might have and will do everything in our power to treat your condition."

The old man, who had been healthy until this moment, remained quiet and pensive until he asked, "Doctor, how long do I have to live?"

Looking towards the door through which he had just entered, the doctor replied, "Unfortunately, we believe you only have one year to live."

Then the old man, who was now a patient, underwent many tests and procedures, spending little time at home with his daughters and their families and living many days in the cold, sterile and uncomfortable room of the hospital. With each month that passed, a new area of the body was examined to look for spreading of the cancer: first the heart and then the lungs. Next came the intestines. Then the abdominal cavity, the liver, and pancreas underwent scanning.

Despite 5 months of testing, no other cancer could be found.

In the sixth month, the tall doctor discussed with his apprentice that they would next look for cancer that may have spread to the brain. If found, however, this would mean that the cancer was truly incurable and would likely decrease the patient's expected survival, proving fatal within a month, rather than a year as previously thought.

Again the patient underwent a test, this time to examine his brain. He appeared weak and frail. His arms, once strong and able, now struggled to raise a cup of tea in the morning. His face, long and with the appearance of bones, was no longer full and soft to the touch or to a kiss. And though he felt pain in the tight machine as it circled above him, he did not speak, as he knew this would further draw out the length of the exam.

This time, unlike those before, the scanning test showed cancer, and the prognosis was grim. The doctor and his apprentice again entered the patient's room to deliver the sad news and inform the patient that he should make arrangements for an imminent death. To the patient, they asked, "We have your test results for this month. Would you like to hear them at this time?"

Now the old man looked up directly into the eyes of the young apprentice. His breathing had noticeably worsened since he first went to see his family physician, and he lay in the cold bed, covered only in a tarnished white blanket that had warmed many others passing through over years. He had not been up to walk in the woods each morning, nor had he seen his daughters and grandchildren in recent times.

"No, I would not like to hear. What will come of these results? If similar to previous months, then nothing will come but another month of tests. See that I have been here for half of a year. I have trusted you with my health, but I am tired now and am finally an old man. You gave me a year to live. I have six months left of life from the time we began. For this seventh month, I would like to return home. I would like to be with my family for the time I still have. It is not a long time I have left, but it is a good time still, six months. Yes, for the seventh month, I would like to be by my family. For this month, I would like to rest."

FAMILY MEMBER

Raymond Morales

Her beautiful brown skin turned yellow
As her personality dissipated
She broke out into a familiar chorus
"Mommy, Please!"
And threw her hands in the air for something only she could see
Delirium had been set in
Crying within, her son struggled in
He and his sister caressed her forehead at the bedside
An avalanche of tears
Landslide
A Thanksgiving break like any other
Filled with traditional food and time spent with my mother
And the usual hospice visit to watch the death of another

SELF-DIAGNOSIS

Terry Kho

The heart can only take so much
before it gives
before it becomes
arrhythmic
becomes something murmurous

When this happens
(I am sure it is happening)
I take my stethoscope
dark blue and shiny
from its box
and listen
(auscultate)
breathe

No murmur
but still I feel it
like something off balance
in my chest
the beating
gone awry

Sometimes I think
my body is breaking down
the heart first
then everything else
my stomach in knots
lungs in a twist

They call it
"Hypochondriasis of medical students"
They call it
"Medical student syndrome"
They call it
"Nosophobia"

I call it inconvenient
(*A rose by any other...*)

And say
somebody please
check my pulse

THE GIRL WITH THE TUBE FROM HER BRAIN TO HER BELLY

Valentina Bonev

Only sixteen and already a mother to two sons,
Whom she will never care for.
Grandma looks after the boys,
While mom lies in bed,
All day and all night,
In a nursing care facility far from home.
She once had "doll's eyes,"
And was "locked in,"
But today she lies in a hospital bed,
Awaiting neurosurgery,
To repair her ventriculoperitoneal shunt.

Why did she have an atrioventricular malformation rupture,
During the twenty-ninth week of her second pregnancy?
Why did a cerebellar hemorrhage afflict,
This sweet young girl?
Why did her boyfriend,
Abandon her?

Her eyelids open wide,
And her heart rate jumps,
When a stranger touches her for examination.
She rigidly maintains a decerebrate posture,
In all four extremities,
But her darting eyes show that she is scared.

Does she know that she has a tube,
In her stomach,
Her trachea,
And from her brain to her belly?
No one knows.

6. Estrangement

LOSING MY EMPATHY

Aleksandra Yakhkind

May – Bright-eyed and fresh from the books, I start my first rotation on internal medicine. I stay at the hospital until 11 p.m. to get a good history of my first patient. It is three pages long. I come in on weekends to practice writing notes. I find out that a patient is witness to child abuse and file a mandatory report. I pat myself on the back. My intern pats me on the back.

Early June – I am no longer as bright-eyed in the morning. My notes are down to a page. I feel more comfortable "redirecting" a patient during an interview. I look forward to primary care and to leaving my house after the sun comes up.

Late June – My hero, a resident named Ray, effectively counsels a Spanish-speaking patient with multiple conditions at the clinic. He asks about her beliefs and her concerns. He teaches back.

Two days later – I watch Ray interact with another patient with diabetes. He bitches about her "non-compliance" in the staff room. I watch resident after attending fall from hero status in my mind.

July – I write Ray an email to commend him and to say, "I am terrified of losing that desire to connect to and understand patients because of time and routine and cynicism." He advises me to do something that I love to avoid burn out. I realize that everyone has good days and bad days.

August – I am thrilled to start neurology. I find a new hero in an attending who explains epilepsy to a 20-year-old patient who had signed out against medical advice from two other hospitals. The patient agrees to start a seizure medication.

September – Psychiatry. I am told by my attending that I care too much. I face an existential crisis. Another attending tells me that it's okay to care. I start to develop confidence in my own approach.

October – I leave the house hours before the sun is up. My notes are down to two inches and my patient interviews, down to under five minutes. I am on surgery. I am not surprised when I hear derogatory comments on rounds. My friend Katie tells me that she is shocked when she sees an attending care about a patient. I realize that I cannot remember the last time I saw someone care. We talk about what it means to "care" versus "to care." We wonder whether we have reduced an emotion to a task on a checklist.

November – I feel numb during a lecture on cultural sensitivity, something that had been my Kool-Aid of choice during study abroad in college. I scrub. I tie knots. I call my grandparents on my way home. I fall asleep on the phone with my boyfriend. I wake up and do it all again.

January - The holidays. I reflect on how I've changed. My family reminds me of the ways I've stayed the same. I worry that I've lost my ability to care. They assert that I never could. More than half way through my medical training, I am not sure. I hope that they are right.

SMILE.

Gregory Haman

Surgery. Rising before the sun. I cannot enter the hospital through the revolving space-age airlock door. It does not orbit at this hour. The tranquil arrangement of bamboo, branches, and mossy rocks thoughtfully time-encapsulated in its plastic lies motionless. I am transported through a side door. Surroundings are hazy through five-hours-of-sleep eyes. This mist settles every day now. I push off in the direction of the surgical suite, trailing my team.

Their masks go on. My mask goes on. I breathe and my world fogs over. Pausing, this thin plastic shield clears. 'Don't breathe.' I grasp the thought but relinquish it as an urge, then a compulsion forces exhalation. I descend into a mist out of which others, similarly garbed, swim towards me. Draped in blue as they are, I appreciate what I can about them: their height, the angle of their eyes. Their masks are clear. I introduce myself. Among them are people I have already met several times. They remind me.

Contorting my jaw I suck the thin synthetic blue membrane tight to form fit my lips and face. It bows into my mouth. Crunchy. I blast my hot air straight through the weave. For all my facial paroxysms, beads of moisture condense. In ample idle moments I consider, 'Is this mask more for the patient or me?'

Surgery over. Mask off. My attending and senior resident walk ahead and I follow in their wake. I don't know where we are going. They are sometimes talking, sometimes not. Always inaudible. Never looking. Their words are heavy as their faces downcast. Now walking to an elevator. I follow. In the elevator we hurtle towards ground. Now walking down a hall. Descending stairs. Passing through the now revolving space-age airlock door. For one moment we are encapsulated, sealed off completely, and frozen in time. I am pressed against their heels awkwardly and unacknowledged in that confined space scene. The tableaux breaks and we are disgorged on a blindingly bright city street. People bedecked in diverse colors are speaking and laughing, walking side by side. I trail at several paces for I must, not knowing our destination. Not too closely either lest a sudden stop or turn cause collision. We walk two blocks, then a third. Entering a parallel universe we are absorbed by another revolving space-age airlock door. Still life. Ensconced in silence. A new elevator. A new floor. Unacknowledged for the length of the journey, at any point I, in ill-fitting blue scrubs, might have been swallowed by the surface and sank unremarked. Minutes later in earth time, Senior resident followed by me arrive at a patient's room. No precautions posted. Poised to enter.

Her mask goes on. Entering, she is transformed. She floats to all corners, carefully and thoughtfully greeting everyone. Considerate of the smallest things. The weighed, downward slide of her syllables becomes an upward lilt. Her curls bounce, positively buoyed up by bubbly countenance. Sunlight and sparkles in her wake as we exit.

Her mask comes off. The crown of her head angles forward ever so slightly, her facial features recede into the shadows cast by the vines of her curly hair. The creases darken and deepen. Clearing her inbox on her phone, I drift in her wake back to our station. As we come to the conclusion of our journey, a glimmer of hope. Rays of small talk: "How are you finding the rotation?" I am acknowledged. "Well, I'm certainly adjusting to the hours," I chuckle.

Floating to feedback with the clerkship director. I am listened to carefully and respectfully. I am built up and encouraged. "Though I want you to know that your feedback does show some areas for improvement. One resident had this to say: 'Complaints about long hours will never be well received and demonstrate a seeming lack of interest.'" Even self-deprecating attempts to articulate the challenges of adjusting to a new lifestyle have left me marooned. Knocked off course and

adrift, I cast about for anything to hold on to, something concrete. "You might try smiling more," I am advised. "What?" I ask, brow furrowed. "Well, you might practice smiling in front of a mirror when preparing a presentation, or even before entering a room. Just put on a smile before you walk in."

Surgery. Rising before the sun. Passing the frozen space-age airlock door, I regard the idyllic bamboo, branches, and mossy rocks forever preserved in plastic. I pause. With a smile, my mask goes on. The first breath, my vision fogs over. But with the second breath it's clear and I hardly notice.

BIRTHDAY

Heather Dimmitt

Emerging from the usual bustle of the hospital, we were presented with a young patient who was taken to the emergency room for assault. She was exactly 16 years old. When we walked in, she was lying on the hospital bed in a red dress featuring a high collar that revealed a window of cleavage beneath the neck. The dress, while beautiful, was cheapened by dried blood and dirt.

While speaking with her nurse, we discovered that she had been celebrating her birthday at a party when she was randomly attacked. She insisted that there was nothing physically wrong with her. But because she was a minor and because her father did not speak English, her cousin had given the order for her to be sent to the emergency room. She was quiet and did not say much about the stranger who attacked her, but it must have been horrible to have such an exciting occasion turn into a nightmare. Where was her cousin? Her father? Where were her friends from the party? She had been here for almost an hour, and still, no family or friends were by her side.

Since she was physically unharmed, the protocol was to run a few CT scans or x-rays (which would come back negative) and then send her on her way. We left her, and I did not see her again. I asked the doctor what I should write down for her physical exam. He turned to me with an amused look and said, "As far as I can tell, everything is normal. She wasn't really talking to me."

He always looked amused after seeing a patient. This is not because he is a cruel man—it is simply because he sees people in these situations every day. Really, I think he is ironically smiling at his own futility, though he would never care to admit it. This sarcastic amusement that healthcare workers seem to develop is hard to understand. On first exposure, I was appalled that these professionals could be so crass and morbid as to laugh during the sorrow or suffering of a patient. But then I realized that the stimulus for this behavior is the struggle of working in such a sad environment. If everyone were to bemoan all of the details of a torn red dress, who would be strong for the sick? Who would prevail?

Death is just another one of those circumstances. Earlier that day, I saw a patient who came in with a cardiac arrest. EMS said that they thought it would just be another routine transport to the hospital for a seemingly healthy

guy, but while en route, the patient collapsed. The paramedic who was with him started CPR and ordered the driver to hurry to the hospital. He told us that the guy's pacemaker had gone off four times during CPR, unsuccessful in trying to restart a normal heart rhythm with electrical shocks. When they got to the hospital, they wheeled him through the sliding glass doors while still doing CPR. The doctor immediately entered and started giving orders.

During this time, his wife was sitting in a chair just outside the room. She was crying and would cry out quietly whenever they shocked him. The doctor would periodically go over to her and try to explain what was going on and that they were doing everything they could to save her husband's life. In the end, when they found that he was in asystole, everyone knew what that meant. Everyone, that is, except the wife.

You could tell that she still had some hope because she did not know what the word "asystole" meant or what a contracting heart should look like on an ultrasound. The doctor ordered the paramedics who had been doing CPR to continue just a little longer to keep this farce alive. He went to the patient's wife and slowly broke the news. I did not hear what he said but you could tell by the level of her weeping that this hope was slowly being wrenched away from her. He tried to make it as painless as such a thing could be. He offered her his support—a hand on her shoulder and a soft, calming voice.

The practice of having a patient's wife present in the room while the emergency team works on her dying husband is fairly uncommon. Often, the family is kept in the waiting room and the doctor comes out after the fact to break the news. I don't know why they brought her in, but her presence drastically changed the whole mood of the code. The atmosphere of a cardiac arrest case is always different. Sometimes it is very solemn and sad like this one. Most of the time, though, people try to maintain a fairly light atmosphere. It is often that you see people laughing at seemingly ridiculous things while, at the same time, administering life-saving procedures.

It is difficult to watch someone die. Healthcare workers regularly use sarcasm and humor to abate the trauma of this experience and to distance themselves from sorrow so that they can continue treating the patient. One of the EMS trainees, who was standing next to a box of gloves during this code, was called over to help do CPR, but he just slowly responded that he couldn't help because he didn't have gloves on. He stood there, trying to fumble them on over the course of about 10 minutes, while everyone else commented on how pale and spooked he looked. Eventually, they proceeded to forget he was there.

Without a certain humorous detachment from the horror of the situation, healthcare workers would consistently hesitate like the pale student. And no one would benefit. Even on your birthday, you have to be able to laugh at what the world throws your way.

Later that day, after coming out of a patient's room with the doctor, a nurse came up to him and told him that one of the other doctors had injured himself in the bathroom and was calling for his help. She said that it was so serious that he was even thinking about checking himself into the hospital.

The doctor looked serious and proceeded to follow her to the break room, making a quick crack about how he hoped he didn't have to see his fellow colleague naked and injured. When we got to the break room, there was a resounding yell of "SURPRISE!" preceding the view of a princess cake with a princess tablecloth underneath it. The uninjured colleague was standing there laughing and the doctor smiled. It was his birthday, too.

Later that night, when everything had died down and people in the outside world were sleeping, we waited for them to wake up with chest pains. Sitting there reflecting on the day we had, that classic lullaby song came on over the intercom. This song is always played at this particular hospital when a baby is born so that everyone can celebrate it. A new life coming into the world. A new birthday to celebrate. This instrumental version of the song always calls up the words from within my memory.

At the thought of "Go to sleep, go to sleep, go to sleep little baby," I began to reflect on my day, ready to prepare for sleep after 3 am when my shift ended. The assault, the death, the party, and now this new life. All associated with the most common holiday celebrating or remembering an individual and the social expectations that accompany it. It was quite a day, but it was also a fairly common type of day in the ER, reminding us all that to live another year of them was something to celebrate.

in uniform

LC

"Bed 23 is having a panic attack"—
and so we would rush in,
quick to form a white fence around the thin steel bedframes
the uniform blue-grey stripes on 23's pajamas
as we assumed position,
armed with sedatives
wielding
diagnoses hanging around their necks, bent,
looping around the
lines drawn by the DSM.

TWELVE SHOTS OF TRUTH FOR A PHYSICIAN IN TRAINING

Romany Redman

1. You are exceptional.
2. You are more the same than you ever will be.
3. Medical training is dehumanizing because you become desensitized and lose your humanity.
   This is a tragedy and pitiable.
4. Medical training is dehumanizing because you become hypervigilant to a supernatural degree and cast off your torn and heavy coat of humanity to ascend to and assume the pedestal of awe-inspiring objectivity.
   This is admirable and commendable.
5. This objectivity is true. All opinions are equal but some are more equal than others. And then there is you. Breathing comfortably. Lethargic. Well-dressed. Cooperative. No acute distress. Yes, you can distinguish the nihilism of philosophy from the nihilism of pathology, multiply pack-years by two, and infer the past from a point-in-time. You are needed for this gift; patients need you for this gift.
6. This objectivity is false. Simply a pseudonym for wind-blown, wave-thrown, you-colored glasses. If you actually knew the meaning of life, then you would just share it and thus motivate your lowly patients to 150% compliance, bear only good news, and rejoice with every reverent, therapeutic touch.
7. This dichotomy of objectivity is real.
8. All dichotomies are false. To quote an acquaintance, "If I say one more time that a dichotomy is false, I'm going to barf. But literally all f#$%ing dichotomies are false."
9. Your skill lies in your enduring heart and in your connections with dynamic, beautiful, hating, loving, hurting, growing, dying fellow beings.
10. Your skill lies in a robust set of ventricles and a clever lack of pesky, earthly relationships. Keep your head clear of the clouds. Those fluffy clouds are not warm blankets holding down fruitful air, rather they obscure the view of ultimate, sterile clarity.
11. When a patient walks in and needs a hug, remember that, first and foremost... Wait a minute! Why are they coming to you for a hug?! Wasn't this visit about hypertension, not hugs? Did you embark on all this training to become a hug distributer? Stop. There are no minutes to wait. No pause to ponder. Quick! High-yield associations:
    When a patient walks in and needs a hug, remember that, first and foremost, needing hugs is an unsustainable coping mechanism. Note the patient's life circumstances and note the patient's response to those circumstances. Appreciate that the pathology always lies in the latter. If there is a pathology, there is a pill. Remember, in vitro is only two letters distinct from in vivo, and in vivo just one language away from life, and life simply short-hand for lived experience.
    Even though this patient could coach all the courses on coping, even though they have honed to the finest degree the intricacies of resilience and strength to a level more superhuman than your assumed objectivity, your unreal insights into life expect, even demand, the unreal.
12. When a patient walks in and needs a hug, do the incredible, the unbelievable, the awesome, the humbling. Break those laws of physics, yet find the reality.
    Simultaneously give and get a hug.

7. Grief and Tears

HEADED HOME

Elle Sowa

I see her tears streaming down,
I read her red eyes.

"What's wrong?"
"He's – gone," she responds.

Henry, an eight-year-old boy,
in weeks, he will be headed home
and leave the rehab hospital.

Cough-
Spray-
Cough-
Splatter-
Cough-
Stream of red
pooling on the linoleum.

Pale, pulseless,
sweaty sheen of his face,
limbs limp,
lying still in a stream of red.

Frantic footsteps, sprinting,

"Call a code!"

I rarely weep.
Weddings, sad stories-
when have I wept at those?

But as I headed home,
I cried.

THE POETRY OF NAMING THE NAMELESS

Emily Pinto Taylor

"She keeps coughing," her sister said,
"and I've been giving her some of my Vicodin, is that okay?"
(Even as a student, I think it's probably not.)
"Cough for me. Again."
"Deep breath in."
"Again."
"Again."
(Later that night, I highlight over and over in my review book
the key symptoms in the presentation of the disease.
Cough,
wheezing,
pneumonia.)
"Again."

I tell her that she, the 40-pack-year smoker who's down to 2 cigarettes a day
("Sometimes 3, doc, I gotta be honest, but not often!")
has earned herself a chest x-ray,
and she asks if she has to take off her gold cross necklace
or if she can just spin it around so it hangs down her back.
I help her take it off.
(Later, I wish I had let her keep it on to protect her from
associated phrenic nerve palsy, recurrent laryngeal nerve palsy,
Horner's syndrome.
Was her eye drooping?)

She lies down on the cold table, and we wait
impatiently, I stand with the attending in the other room and wait for the scans to upload
as the tech comes in and asks if we heard anything over her right lung.
My heart feels bigger and bigger, pushing out against my chest
and I feel my own lungs, especially the right one, expanding out as I gulp air
and the attending next to me sits down, head in his hands
and practices his poetry.
"Fuuuuuuuuuuck."

When we tell her, she's stoic, and we laugh together on her way out
but I work on her note for over an hour later
because I want it to be clear that she didn't earn this, no matter her pack years,
and because as there is a poetry in burying your loved ones after they die.
There is also a heat, a palpable love that is born in a room when you recognize mortality
and name it, and form an alliance
together.

I write her assessment and plan
and close the encounter
but that heat follows me home.

ONCOLOGY SLEEP

Tavis Apramian

Dr. M is a medical oncologist. He's the kind of oncologist who blends encyclopedic knowledge of transcription factors with the writing of scholarly articles about the nature of hope. He's the kind of oncologist who touches a woman's knee when she starts to cry and it doesn't feel forced. He's the kind of oncologist who, with an impish smile, corrects his residents when they say "she's an adenocarcinoma" to "she's a woman with adenocarcinoma." He's the kind of oncologist who tries to pay back the stories patients tell him with stories from his own life about his wife, his daughter, his father, his house, and his cello. He's the kind of oncologist who has a hundred different ways to tell someone they will die soon depending on the way they want to hear it.

***

Sid wants to make it to spring so he can ride his motorcycle. Three or four months, that's all. Though he looks healthy, and huge, Dr. M's declaration to me outside the room that he likely has two months left to live weighs down Sid's words as soon as he releases them. It seems like so simple a request.

Despite his orange t-shirt and black leather vest, he's brought his mother to his appointment. They look close in age. She is cheery, and I like them both. Dr. M starts to talk specifics (new aspartate aminotransferase elevation despite last option chemo), but Sid and his mother are talking in non sequiturs about the walks they've started taking again and the fatigue he's feeling.

"This whole body is mine," he seems to be saying. "Don't break it into little pieces."

I can feel them pressing Dr. M for a less detailed answer. They want to know how many walks are left. Will he make it to spring? Plaintively, Dr. M spreads his hands in the air, palms up. His face says no. After a pause, he speaks,

"It is out of my hands."

And, in that moment, it feels like the humble finality of his answer is what they wanted. Their walks will now be to say goodbye, and the bike will stay parked in the garage until spring comes and he is gone.

***

Russian newlyweds are in the room along with the wife's mother and grandmother: three generations all at once, and a fourth to come.

He speaks softly and his hands are rough carpenter's hands. The lump in his side, long since flung to distant organs, now catches on the inside surface of his ribs when he tries to build houses, hammer nails, cut wood. She asks Dr. M:

"Is he in pain?"

Wordlessly, she paints a picture of him, inebriated opium-high, climbing ladders, swinging hammers, and drawing saws.

They are young, and he wants to build until he drops. Someday, after he is gone, maybe she will be able to buy her own house with the money he makes in these last days.

She lets flutter out of her sleeve an ace she's been holding: a creased computer printout on the chaga mushroom, a Russian herbal remedy. As she fingers it, her grandmother whispers resignedly in her mother's ear. With nothing left to lose, the wife gambles that the mushroom is the one cure he has forgotten.

He sets the printout on the bed. He tells her softly about the things he knows and the things he doesn't know. She nods and cries silently while he passes an opioid prescription to the husband and tells him it is probably time to cut back on the dangerous stuff at work.

***

I tried to keep up with Dr. M as best I could as I follow him through those white rooms. I let myself try to follow the conversations of mutagenesis without showing what I did know or pretending I knew more than I did. I allowed myself to share conciliatory smiles with people so sick I would never see them again while remaining ghosted into the background. And I'll admit it. It emptied me out.

So empty all I could do was sleep. So empty I didn't realize I was empty until the next day. Even thinking now about how I felt yesterday makes me empty again. All the things I thought were good became wasteful. My own motives became wanton. The world became hostile and aggressive: a machine for breaking people. I was stripped bare. And that was only on my first day. But at least it was only my first day.

Witnessing death stare at you, all-knowing, is a consumptive task. The time you've wasted, the things you've never done, and the lies you've told yourself are all revealed. It is inescapably unnerving. I saw here that becoming a fully fleshed witness to the harsh omnipotence of death is a learned skill.

I'll learn, too, how to hear from someone who is suffering, to give myself over to their story, and then to rebuild stronger, like a muscle.

***

Last night, while I slept, a man came to me with his cancer. He didn't know much about it, except that it scared him. I asked him to open his mouth, and I looked inside. It grew out of every junction. It grew out, green and treelike, from where his tongue met the bottom of his mouth. Down his throat and into his muscles and membranes and tissues. It had its own fleshy plant structure: all stems and waving green branches and seed pods. It was well rooted and greedy. It pushed its way into the spaces between the different parts of him. It made him its home. They lived together, the two of them. They were joint animals. The same creature and, at the same time, not.

When I pulled my vision back out of him, he snapped his teeth shut like a gate and smiled at me. He was an average man again, indistinguishable from any other. But in his smile I knew we shared a secret. He harboured a growing life inside him, and he had shown it to me like a gift. He turned on his heel and left me standing there to sort out the pieces of myself and the world of his cancer with clumsy, well-intentioned hands.

8. Thank You

THE GIFT OF DEATH

Jen Stone

Dedicated to the lovely 77-year-old female at Table 26

You provided me with opportunity.
You prompted an explosion of curiosity.
You forced development of patience.

You are truly selfless in your absence.

You gave me the indescribable.
You gave me the unattainable.
I am forever grateful for your gift of death.

ALIVE BY DEATH

Catherine Gonsalves

Speckled brownstone clay

DEAR NORMA JEAN

Julia Saling

Pencil on Paper, 8"x11"

Dear Norma Jean,

Do you mind if I call you *Norma Jean?* I couldn't bear the thought of calling you she or a number, or worse: it. I started referring to you as Norma almost instantly to avoid what I felt as neglect of everything that made you more than a body. In some ways this helped me cope with dissecting a person, a human being. I never once let myself see you as anything less than Norma Jean. You were so much more than a gender, age, and cause of death pinned casually on the wall.

It was only after reflection that I saw how much you paralleled the song "Candle in the Wind" by Elton John. He sang of Marilyn as he would have liked to know her, as she really was: as Norma Jean. When I noticed the identifier number inked onto your chest, all I could think about was how your true self was also hidden from me (though for good reason). *They made you change your name.*

I felt very disconnected from you at times. You were my first patient, and I felt you deserved my utmost respect and attention. I imagined what you might have been like. When the dermatologists came to teach us, I learned so much more about your humanity. "The subject had extensive sun exposure on her legs, at the calf, and on her forearms." You liked to wear capris, didn't you, Norma? I imagined you sitting on your front porch enjoying the sun spilling onto your legs and warming them.

And they whispered into your brain. I have never been this close, so intimate with another human being. The concept of touch is so daunting. Even though you couldn't feel, I treated every cut as though it may have pained you. I was delicate and directed, making as few incisions as possible. At one moment, when we removed the cloth coverings from your face, a small fragment remained. I wiped it away, thinking how much you would have hated being seen with a blemish disgracing your features.

Genital dissection pained me greatly. I felt more kinship with fiendish mutilators of young women to circumvent sexual activity than what I intended to be—a scientist learning the geography of the genital landscape. I saw the deepest parts of you, Norma, but I never knew you. I would have liked to know you, but I was just a kid. I would have liked to know if those wrinkles around your eyes were brought on by laughter as you sat on your porch in your capris with loved ones. Or was your long life filled with sadness that pulled on the edges of your eyes with a burden heavy enough to make them droop? Maybe it's both.

Even though you are gone, I was still able to learn from you. *Your candle burned out long before your legend ever did.* You have given me a wealth of knowledge that I won't truly appreciate until much later on. I will never again be probing the depths of another person in this way. I will never know so much and so little at the same time.

Goodbye, Norma Jean, though I never knew you at all. Thank you for your gift. Thank you for your sacrifice. But most importantly, thank you for your life.

Sincerely,
Julia R. Saling

Note from the Author: While studying anatomy, I was greatly moved by the experience of working with the person now dead. Often I was confronted with a mix of emotion with which it was difficult to come to terms, alternating between feeling guilt at defacing a body and the appreciation of the gift of knowledge. Many times I found myself wondering what my cadaver was like during her life. It was not until I was given the opportunity to reflect on my experiences that I found closure through writing a letter to my cadaver.

GRATITUDE

Kevin Dueck

She came into the clinic struggling to carry all that she had brought. A purse over one shoulder, a plastic bag slung at the crook of her arm, and both hands holding something delicately covered in foil. The nurse greeted her, checked her in, and directed her into one of the small consultation rooms.

When we entered the room, the object in foil was sitting on the counter – the plastic bag beside it. Her face lit up upon seeing the surgeon. Through her thick accent she thanked the doctor for what he had done and proudly removed the foil. It was a cake, made from scratch. She had made it for the doctor and the staff. From the plastic bag came paper plates and cutlery. I had seen patients express gratitude before, but this was something more.

What had the surgeon done? I expected it to be an emergency surgery that saved her life. No, her diabetic foot had been amputated.

Removing a part of someone's body and being thanked for it – this is where I start to struggle. Receiving not only thanks, but also a cake, for cutting off a part of this woman's body – it was hard to wrap my head around. I could easily recite the benefits of such a surgery: no further foot ulcers, worry of infection, wound care; yet, it still does not feel quite right. Removing a cancer is like dealing with an invader – something foreign – and, thus, different than removing a still functional part of the body. This part of medicine is going to take some getting used to.

TRANSFORMATION

Lyndsey Cole

As we enter the anatomy lab, cuts become incisions, bodies become cadavers. These cadavers—our first "patients"—lie supine on the dissecting tables, dispassionately numbered. They are our grandparents, our aunts, our uncles. Our parents. They are time in itself—forgiving yet unyielding, infinite yet ephemeral.

We alone possess this unnatural privilege to explore the human body in so literal a manner. We inspect the cadavers, piece by piece, organ by organ, fiber by fiber. We locate each muscle and name it: action, origin, insertion. We trace each nerve and artery and vein; they, too, are each carefully identified and named. We name ducts and glands, lymph nodes and bones. We name everything in the body, except, of course, the body itself. All of our knowledge cannot tell us this—the name of the person, who they were, what they stood for. The very essence of the person who we have come in such close contact with—that is kept an enigma. With every scar we see, every wrinkle we feel, we sense the ubiquitous weight of all that we cannot know.

The questions multiply, and we wonder about the falls that gave the scars, the laughter that formed the wrinkles. We know anatomy can reveal disease and inflammation and abnormalities, but can it show us a person's happiness? Can it show us loneliness, or hopefulness, or belief? Can it show us love? Impenetrable, these crucial elements are invisible to us as we invade our cadavers. We will not ever know these people, though we have known them in a way unique to any other. We realize this, and in recognizing it, we see the beauty that is missing from this mechanical practice, and though the purpose was to teach us structures and appearances and

positions in the human body, we have learned something else, something more important. We have learned what it is that has drawn us to this profession—it is not the organs, the bones, the muscles—it is the human spirit and the connections to be formed with others as we heal them.

And so, as we enter the anatomy lab, cuts do become incisions, bodies do become cadavers—and we?

We become doctors.

CONVERSATIONS WITH ALFRED

Parin Patel

I come in each day to see how Alfred holds up.
Day by day, he deteriorates more and more.
I see his eyes begging, imploring,
and I wish we could stop,
but that would be the real crime.
We are bound to pulling him apart like he is bound
to the table.

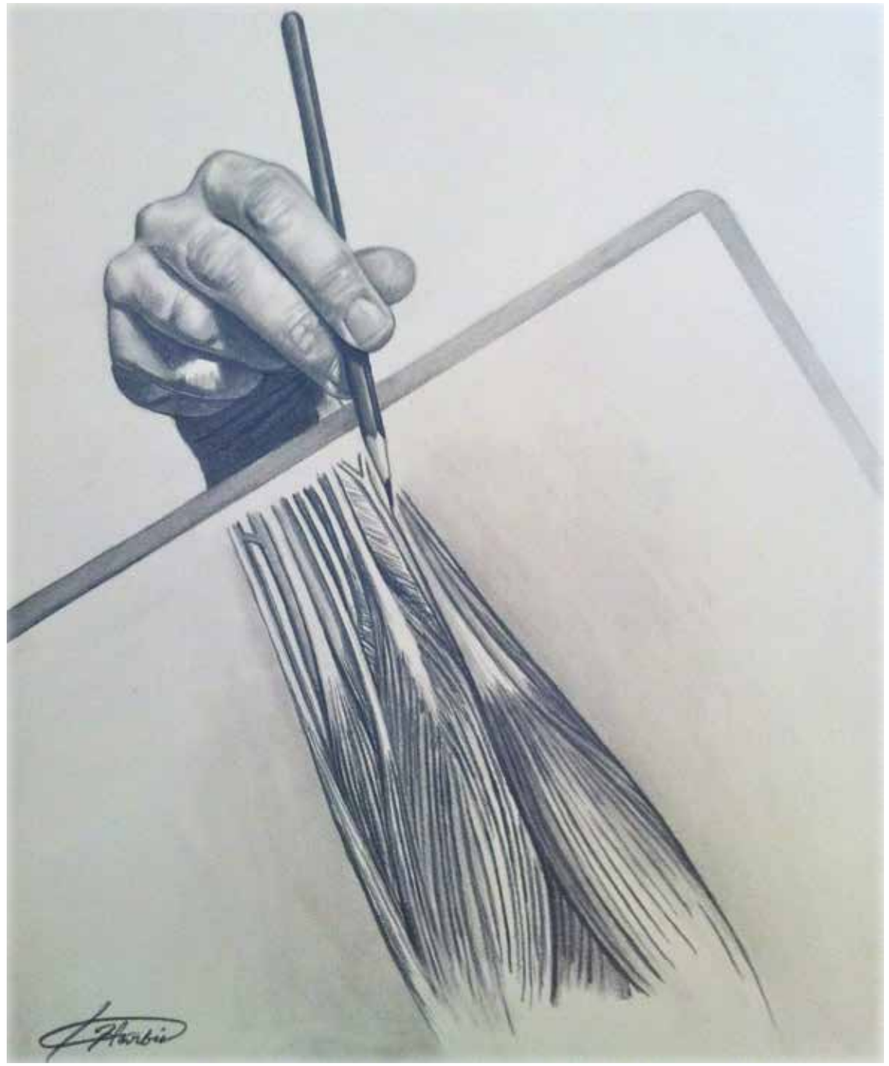
"Alfred, how are you today?" I ask him. "How are you holding up?
I see you are tired, but then again you're always
tired, aren't you?
Here, let me move that block. Is that better?
Let's move these flaps of skin so we can cover you up
and so you won't be cold.
I know this may not have been what you expected, Alfred,
but we're trying our best. At least I know I am.
I'm not sure if you thought of what I think of
when I think
about being a cadaver."

I wonder…
Will they appreciate me? Will they just tear me up?
Will they see the humanity that once made me me?
They should do their best to learn from me, even though
I am not perfect, probably because I am not perfect.
I hope they will be patient, for with time, I will reveal
all of my secrets.
And they and I, I and they,
will know each other like day knows night,
like a flower knows the sunlight. And that bond
will surpass all ordinary bonds.

THE ART OF ANATOMY

Khalil Harbie

Pencil on paper, 8"x11"



FIRST-YEAR ANATOMY LAB: A SIGN IN LATIN ABOVE THE DOOR

Richa Vijayvargiya

I came to learn
and I thought
you delighted to teach.
And so,
banishing idle talk and silencing laughter
I entered.
But maybe instead of teaching
you touched
us,
and our hands,
giving them life and a new understanding.
And in doing so,
Your body will continue
to touch,
to comfort,
and to heal
every single patient to come.
Truly,
your gift is a gift that keeps on giving.
How young of me to think any different.

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