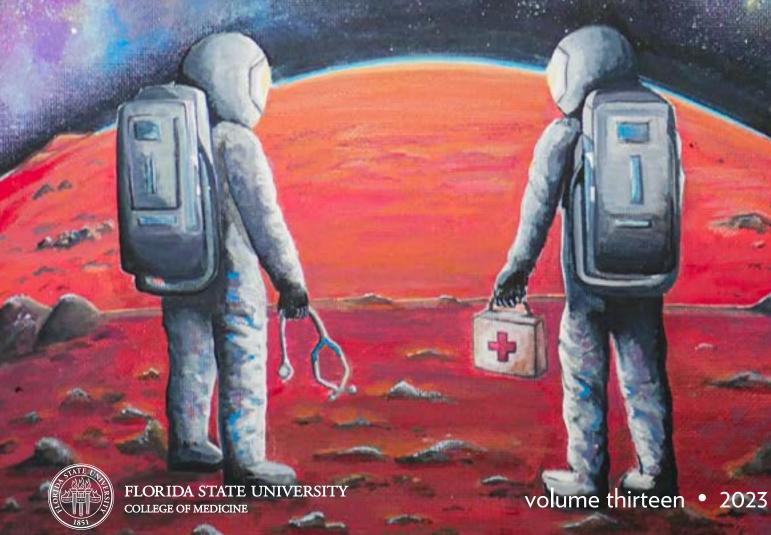
## HE A L

Humanism Evolving through Arts and Literature





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## LETTER from the Editor

The cover of volume thirteen—a painting by PA student Michaela Manias entitled "Medicine Across the Universe"—conveys both the excitement and uncertainty of the future, but also the comfort and value of the known. Manias chose to paint two astronauts traversing Mars, while holding medical equipment, to elucidate her love for both medicine and space. Manias also wanted "to symbolize the feelings" we have when we start something new. "Whether it be your first day at a new job or your first day of clinical rotations," Manias notes, "you may not be in your comfort zone, but you will always have your foundational roots, which are represented by the stethoscope and medical kit. Faced with something different and daunting, like visiting outer space, you might feel like you know nothing, but your rudimentary knowledge will always help you through future experiences."

This year's "Humanism in Medicine" essays exemplify this—each of our three winners describe venturing into unknown territory during clinical rotations, only to learn their fundamental humanity was all they needed to provide relief and care. Whether giving the patient their undivided attention, offering a sip of water, or helping a new mother navigate loss, each learned their limited medical training did not keep them from making a positive impact on their patient's healthcare experience. As second place winner Natalia Correa writes, "My only hope is that we all recognize our ability to impact others simply by showing up and connecting. Our degrees may allow us to help in other capacities, but if we arrive without ever connecting, we might as well not arrive at all."

The prose, poetry, and art that follows depicts a wide array of experiences in medicine so that we all might reflect on what it means to learn, grow, and move forward into the future with compassion and love.

Warmly, Tana Jean Welch, PhD



### On the Cover

### MEDICINE ACROSS THE UNIVERSE

Michaela Manias PA Class of 2023

Michaela is a second-year physician assistant student at the FSU College of Medicine. She loves creating art and is fascinated by outer space, biology, LOTR, and practicing the Greek and Spanish languages.



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### Someone who

Isabella Amador

Unzipping the blue bag
Heart racing, breath hitching
Eyes searching for what
I feel unprepared to see
The body of a loved one, someone
Who is unknown to me

Their delicate hands clasped
As if in prayer, wishing
For safe passage beyond
Hands holding one another
The body of a loved one, someone
Who was once a mother

Their legs resting at ease
Once travelled our world
Exploring its many wonders
Legs that could run a distance
The body of a loved one, someone
Who lived an entire existence

Their eyes are closed, tranquil
Eyes that once cried and marveled
At all beauty they witnessed
A changing world they'd seen
The body of a loved one, someone
Who was once a human being

Their mighty heart, idle
A vessel of emotion, devotion
Broken with loss and mended with love
Fueled on by tender care
The body of a loved one, someone
Who is no longer there

Once vibrant, glowing, full Now dormant, cold and grey Gone on a journey unknown A teacher who will be missed The body of a loved one, someone Who gave the ultimate gift Isabella Amador is from Puerto Rico and is a second-year medical student at the University of Florida College of Medicine. She enjoys reading and writing as an outlet for managing stress and balancing her life as a medical student.



### HAPPY MEALS & END OF LIFE CARE

UTAH HIKES, ZION 3
Emily Gansert
Class of 2024

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

Sarah Smith, DO

Outside my office window, in the suburban Tampa parking lot, there is a wild-eyed raccoon. He is scurrying between the different sidewalks that lead to the insurance office, the physical therapy building, and the law firm like a maniacal hustler.

Inside my office, a thin, eighty-year-old gentleman sits quietly in room one. I noticed, on his way in, that he dressed up today. His brown jacket highlights the golden tinge of his skin.

Unfortunately, I don't know much about him. We met just a month ago. He was polite and businesslike on that first visit. He came in complaining that he "always felt full." We discussed his worrisome weight loss and nausea, but I never had a chance to ask the questions that make someone feel more at ease, like how many children he had or whether he golfed.

I sit at my old wooden desk and review his results again, preparing to discuss the grapefruit sized tumor in his abdomen. I wish I knew him better. I wish I knew if he had any type of support system.

The sun streams through the hazy window, and I notice the raccoon is now camping out under a car. His body is slumped against the rear tire. He looks kind of adorable, and I just hope he sleeps the rest of the day.

I knock on the exam room door and enter, stating warmly, "Hello Mr. Evans! How are you?" My patient stands to shake my hand, and I notice he is tremoring, as if he already knows what I need to discuss. I pull the small rolling stool up, right next to his chair, and I show him the CT scan report. Slowly and carefully, I explain to him that there is a tumor in his liver that is very suspicious for cancer. He nods, and then, he immediately begins to tear up.

I pause and grab him a scratchy paper towel. I secretly curse myself for not having soft tissues for moments like this, especially as often as people seem to cry at my office.

"I can't think straight," my patient says, shaking.

I respond, "No problem. I'm going to give you a couple minutes to collect your thoughts. I'm going to give my favorite oncologist a call and get you in to see him as soon as possible. Just wait here." I step out into the hall and ask my medical assistant to call the oncology office a couple miles down the road.

Meanwhile, the raccoon is awake now, and he is licking the door mat in front of our office door. He stops for a second to aggressively hiss at an elderly woman coming in with a walker.

Back at my desk, I type "rabid raccoon behavior" into the search engine, and I ask my medical assistant if she can call animal control after she gets off the phone with the oncology office. She nods understandingly.

I look through my patient's chart again and see in the social history that he checked widowed. There is not an emergency contact listed.

"I scheduled an appointment tomorrow at 9 for Mr. Evans with Dr. White, but animal control says they don't come for raccoons or any small animal. They will only come for gators over six feet," my medical assistant yells down the hall.

I'm not surprised. I've honestly never gotten animal control to help in the last fifteen years I've lived in this swampy state, and I once had a panther in my backyard.

Just then, a man who will forever be referred to as "Florida man" speaks up from the waiting room. He pokes his head through the receptionist's window and says, "I'll catch that raccoon for you and put it in the dog crate I have in the back of my truck."

"But then what will you do with it?" I ask concerned, but I'm honestly just relieved that he didn't offer to shoot it here in the office parking lot.

My nurse practitioner pipes up, "My daughter's best friend's mom is the vet a couple miles down the road. I bet you can take him there. She buys every animal a Happy Meal before she sends them to heaven."

I look outside again, and the raccoon is walking in circles frothing at the mouth. "Good plan," I agree.

Before I know it, Florida man borrows a lady's rollator walker and uses it as a makeshift weapon to corral the raccoon into his dog crate which he lifts into the back of his F150 truck. With the biggest grin on his face, he waves to us as he pulls out of the parking lot on his way to the vet's office.

I walk back into room one. Mr. Evans has calmed down, and I ask if he has any children or other family. He shakes his head no and whispers "only a little dog." I want to give him a hug, but instead I ask what the dog's name is. Her name is "Jackie." He adds that the only thing he really cares about if he dies is who will take care of Jackie—and that he is scared to be in pain.

I take a deep breath as I internally debate if it is appropriate to offer to care for Jackie. I say, "I promise you that I will help you with everything. Let's wait on making any plans for Jackie until you speak to the oncologist tomorrow." He agrees. I write down the address and directions to the oncology office. I prescribe ondansetron for nausea and set up another appointment in a week.

Sitting back at my desk, I can't help but think about how, at the end, the only two things that really matter to my patient are who will take care of his beloved dog and his concerns about being comfortable. Does a whole complex life ultimately add up to that?

Just then, my medical assistant yells down the hall again, "Vet is on line 2." I pick it up and she tells me that the raccoon is now in peace. I ask if he got a Happy Meal, and she responds in a matter-of-fact tone, "Of course! Everybody deserves compassion."

I respond, "I completely agree."

Dr. Smith is a board-certified family physician, an author, and a mother of two. She has also been published in Kevin MD, Intima Journal of Narrative Medicine, Pulse - Voices From the Heart of Medicine, and Sheila-Na-Gig online. She holds a Bachelor of Arts from the University of Notre Dame and a Doctor of Osteopathic Medicine from Ohio University. She lives in Tampa, Florida.

### CHEMOTHERAPY CLINIC

Paul Rousseau, MD

Rosie is 85-years-old. She is bleak and bone-thin, her skin slipping from shriveled arms. She laments the physical and mental decline that accompanies chemotherapy, and asserts she is ready to die. I support her concerns, however, her family obliges her to continue treatment. They refute the debility of her symptoms and allege treatment bias based upon her advanced age. I inform them it is not ageism, but rather a fear she may succumb to the devastating consequences of treatment without any therapeutic benefit. They stiffen in resistance and declare her pallid skin "glowing," her hollow eyes "girlish," her weight loss "healthy." My head jerks; I am appalled. Their response is shameful. I appeal for understanding, but they are determined. "She's a fighter," they proclaim. "She'll get through this." I glance at Rosie. A ragged sound rises from her belly; she reluctantly defers to their demand.

I am frustrated and angered. The family's decision is clearly based upon their welfare, not Rosie's. They are not tethered to a bag of chemicals. They are not intimate with the local pharmacy. They do not gulp handfuls of pills. They do not gag on Boost and Ensure. They are not exhausted from stabs of pain. They are not alone and ailing.

Rosie's head droops. Strands of filament-like hair drop onto her lap. She frowns, plucks them from her pants, and rubs them between her fingers. Her family prods her to wear her wig, admonishing, "It's better than that old bandana you wrap around your scalp." Rosie nods. I notice a glint of tears in her eyes. I grudgingly relent to the family; I have no choice. Letting go is hard.

Dr. Rousseau (he/him/his) is a physician and writer published in The Healing Muse, Blood and Thunder, Intima: A Journal of Narrative Medicine, and other literary journals.

ond-year medical student at FIU HWCOM and is President of their Medical photography and videography behind her Canon lens.





### WHOOPER UNITY CALL Kathleen Wilcox

Kathleen Wilcox is a contemporary enamel artist with a studio in Tallahassee, Florida. Her award-winning enamel wall pieces are exhibited and sold in Juried Exhibitions, Art Museums and Galleries.

### Haze

Sean Gabany Class of 2025

Falling or flying, sun bathes me with warmth as I crumble to ash. Wind dancing through my hair as I'm sliced to tatters. Sky is sea, welcoming me. The heavens are oceans threatening to consume me. Tears are release, of suffering? of joy? Mist hides all, perhaps salvation? Perhaps damnation? Where does it go? The leaf in the winddoes it fall from the tree or fly away? Finally free or doomed to decay? Black and white only yield grey. While adrift, there is one truth, whether you fly or fall... you cannot stay.



THE GREAT SMOKY MOUNTAINS: GATLINBURG, TN
Nida Mohyuddin
Class of 2023

### Lot's Wife is a Future Physician

Sydney Cabana

Red light, caged rats rustling in darkness,

Congratulations! Welcome to medical school!

Desperate claws, please, please anything but that box again—

I did what I had to to get here.

This morning sullied by the stench of rusty rat blood on my shoes,

A former Mengele, ever-haunted by her crimes.

In purity and holiness I guard my life and my art.

On the first day of anatomy lab I saw a cadaver

But not my first one.

I grew up with Icarus until he flew too close to the sun.

"Use a Stryker saw to cut through laminae C3 through C5. Do not sever the spinal cord."

I stand next to the body bag

like a golden retriever waiting beside his best friend's coffin.

I used to think ghosts had no flesh or bone.

These are your friends for life!

Lean on each other; support one another.

Red light. Choking on morning air. Pictures with your first stethoscope!

Curly hair like the sun. Treasure this time, it goes by fast.

I am swept up in Future's joie de vivre

But in the darkest corner of my mind

The rats are still scratching.

Sydney Cabana is a third-year medical student at the University of Florida interested in pursuing a career in child and adolescent psychiatry.



# A BREATH OF OCEAN AIR James Courtney Class of 2025



### Reach

Sean Gabany, Class of 2025

The ocean
Water cool
Waves crackle
Eternally unquiet
Limitless horizon
Majestic mystery
It's magnificent
Then the sun –
Warmth washes over
Ecstasy dances solar
Facing true contentment
Let me reach it

Against the maw
I crawl forward
A journey against infinity
Treacherous waves deaf to all pleas
Unmovable force
I want to get there
I want to be bathed in its rays

Ominous collapse into darkness Soul swallowing weight Insatiable hunger consumes the sun Fruitless battle against the unfathomable

No!

Muscles ache
Bones' weight
Searing throat as it consumes me
Can't break the surface!
Shadows are all the eyes can see
This icy blanket is truly merciless
As I'm left with one last kiss

Please.
Someone.
Help.
Just let me feel
That warmth

One more time

### THE HEMODIALYSIS LIST

#### Paul Rousseau, MD

"He's not a suitable candidate. I know he's only 29—I'm sorry." I was sitting in a small conference room with Dr. Jones, a nephrologist, and a social worker, a chaplain, and a lay member of the community. I was a medical student rotating with Dr. Jones. Six names were on the list, all young to middle age, the oldest fifty-five. But there were only two dialysis machines.

This was the weekly meeting of the "Hemodialysis Committee," meetings that occurred before dialysis machines were common, before Medicare paid for dialysis, and before kidney transplants were "routine." It was the duty, and burden, of the nephrologist and the committee to determine, objectively, who would receive dialysis. Usually, there were not enough dialysis machines. The decisions were heart wrenching. It was necessary rationing.

The 29-year-old was a drug addict, twice incarcerated, and facing death—from kidney disease. The social worker and chaplain argued that addiction should not be the primary factor in determining who receives dialysis. "I've been through this before, they promise to clean up their lives, and maybe one in a hundred does, but most don't. I'm sorry, he's not getting dialysis. It's hard, I know, I have children myself, but..." Dr. Jones rubbed his brow and glanced at the list. "Look, no one likes making these decisions, but they must be made."

As the meeting neared an end, two names, and one dialysis machine, remained. Dr. Jones grimaced and narrowed his eyes. "She's single, 31-years-old, college graduate, works full time, supportive parents. He's married, 38-years-old, works full time, the father of two children." He heaved a deep breath. "He'll be our second one. Any disagreement?"

an you imagine? Hearing voices that no one else hears. Can you have so much willpower. Some can ignore what the voices tell them to do. I don't think I could ever do that." Nine months into my clinical rotations and this was the most genuine empathy I felt from a physician. I shook my head no. I could never imagine that tragedy.

We walked over to the first patient of the day in the inpatient unit. I only had time to skim the diagnoses she had, which included bipolar type I and borderline personality disorder. She was 48-years-old and had been hospitalized for psychiatric reasons over forty times. The attending psychiatrist and I both sat down in chairs a few feet from her. I was interested to see how my attending would take her history, and I had my notebook and pen ready to take detailed notes. I was surprised when he looked at me and said, "Why don't you ask our patient some questions?" It was my second day on the rotation, and I wasn't quite sure what to ask her or what order of questions was most appropriate. I had no clue why she was admitted here either. I started with the one question I could think of: "So, tell me why you're here." She appeared uncomfortable and not quite ready to speak. She told me she had tried to kill herself by overdosing on metoprolol. Again, I wasn't quite sure where to go from here. I then asked her, "So did you call for help? Did someone find you?"

I could feel in my bones these were not the right questions.

She looked down, fidgeting. I had made her uncomfortable. "I don't want to talk to you anymore. I would like to speak with the doctor," she said.

I fathom how crazy that could make you feel?" I paused in silence as I watched my attending psychiatrist ask me this rhetorical question. These days, since N-95s cover most of our faces, the only facial expression we can see is in the eyes. His brows were furrowed, and creases bordered the edges of his eyes. He continued, "These patients with schizophrenia

"Of course. I understand," I mustered. "Where are you living right now?"

My attending started with his first question to the patient.

My heart dropped. One of my biggest goals in

life is to form meaningful connections. And here

I was, failing to embark on that journey with her.

As he continued with the easier and benign questions, he went on to ask harder and more personal questions. She answered each one with ease. She was comfortable with him.

I felt my head go back and forth during the interview, watching their conversation. His voice was calm, peaceful, reassuring, yet firm and intentional. I could feel how genuine he was. This was what giving respect to your patients looked like. I noticed he had started the interview with his legs crossed. As the interview went on, he mirrored her posture. He leaned forward. He had no pen to take notes. He looked at her directly for the full twenty minutes. He never interrupted her. He nodded frequently, conveying he understood her well. It felt like we had all the time in the world, and that this patient was the only person who mattered in that moment.

As we finished up the interview and stood up to leave, the patient looked at me and said, "I'm sorry. I just really trust the doctor. I've known him a long time now."

A few weeks ago, someone asked me what my favorite failure was and what I learned from it. I smiled when they asked me. This memory came to my mind immediately. This experience taught me critical qualities I must practice as a future physician—respect and empathy for each of my patients. I can tell a patient, "I cannot imagine what you must be going through, but I am here with you every step of the way." I can tell a patient, "I will respect your decisions always." But without action, words are useless. If I cannot form meaningful, compassionate relationships with my patients, then I shouldn't be in medicine. So, what does that mean for me as a medical student?

Laura Samander, MS Class of 2023

It means that when I read my patient's chart, I will sit for a moment and try to comprehend what it must be like to have to be hospitalized forty plus times before I'm 50-years-old. What it must feel like to experience chronic emptiness and loneliness. What it must feel like to not want to live anymore. It means to sit down and really, genuinely listen to my patients when they tell me they overdosed again but don't know why they did it. It means making eye contact with them the whole interview, not interrupting them, nodding to convey I am hearing what they're saying, and that right now—in this exact moment—they are the only person that matters.

Laura is a fourth-year medical student who has applied for Psychiatry residency this year with the intention to work with the uninsured, minorities, and the LGBTQIA+ population.

# **SPACE NEEDLE** Logan Malter Class of 2023

# THE 8<sup>TH</sup> ANNUAL "HUMANISM IN MEDICINE" ESSAY CONTEST

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

## JUST A SIP

#### Natalia Correa, Class of 2023

It was 6:30 in the morning when I arrived at the community hospital for rounds, three weeks into my interventional cardiology flex rotation. The elevator took me to the eighth floor where I met the nurse practitioner I was supposed to round with. We had ten patients to see today, starting with Mr. A.

I met Mr. A yesterday in the emergency room. We were called for a consult since my preceptor managed his hypertension outpatient. The Omicron wave of COVID was sweeping through and the emergency room was overwhelmed. Mr. A was 87-years-old and quite frail after suffering a fall at home. I was hoping to see him out of the emergency department that morning.

As soon as I walked into the room, I noticed he had mitten restraints. His lips were chapped. His mouth was dry. His eyes closed. If I had to guess, he wrestled with the sheets long enough to agitate his IV in the hours before we arrived. There were streaks of blood on the tangled sheets that swaddled him. Needless to say, the sheets won the fight.

As we walked in, the nurse practitioner said, "Good Morning Mr. A, my name is X and I am the nurse practitioner working with Dr. Y, and this is our medical student working with us, Natalia. How are you doing today?"

No response.

"Mr. A, did we wake you up?" she asked.

No response.

We approached the bed and she projected, "Mr. A, can you hear me?"

He mumbled.

I had never been so relieved to hear a mumble.

He tried to speak but his mouth was too dry. He choked. He began to gasp...but for water. He lifted his hands, but they quickly jerked back into the bed as the slack of the restraints tightened. He opened one eye and slowly looked over at the cup on his table. The nurse practitioner picked up the cup, bent the straw, and said, "Would you like some water?"

His eyes opened wide as he weakly nodded yes. It appeared as if she was the first to ask. All I could think was, how long has he waited for someone to ask him that? How long has he waited to have that one sip of water? As he took his first sip, his lips moistened and you could see life enter him slowly.

He didn't stop sipping until the cup was empty. I couldn't help but ponder, is he that thirsty, or is he worried that a whole day will pass before he is offered another sip?

The sound of the straw sucking the bottom of the empty cup filled the room.

We spent the next couple of minutes untangling Dr. A from his sheets. I loosened the straps around his wrist and adjusted his mittens. I refilled his cup with water and offered him some more. As he took another drink I met with a thought. The thought that anyone could do this. Any person that stepped into his room, regardless of their title or level of education, could have picked up the cup and offered him a sip.

No one had until the nurse practitioner.

Mr. A had no family visiting. Mr. A had no family to call. All he had was us. As I complete my third year of medical school, I can't help but recognize the rush we exist in. It is a

malignant rush that affects every industry, career, home, and human. A rush that inhibits us from connecting with others. A rush that prevents us from investing in others. A rush that will eventually harm us and others, especially our patients.

When she offered him that cup of water I felt that rush subside. There was nowhere else to be. There was no one else to be with.

And if there was, was it more important than taking the moment to provide that sip of water?

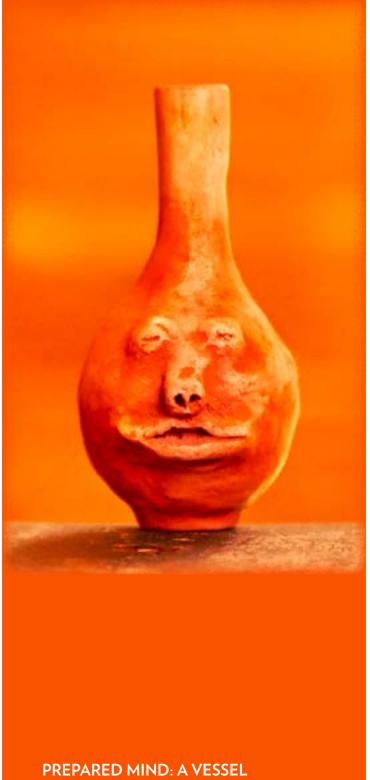
Those minutes we spent giving him water and unraveling him from his sheets were some of the most impactful minutes I spent in that hospital. I could feel the compassion this nurse practitioner had for her patients. When she walked into that room she was not thinking about the next nine patients waiting to be seen. Not to mention the additional 20 that were scheduled to come into the clinic later that day. She made time to connect with Mr. A. It was a connection that allowed her to understand his needs.

My only hope is that we all recognize our ability to impact others simply by showing up and connecting. Our degrees may allow us to help in other capacities, but if we arrive without ever connecting, we might as well not arrive at all.

We do our patients a disservice when we show up disconnected or when we fail to connect.

Connecting with others helps us understand beyond words that are said and actions that are made. It helps us meet our patients where they need us most and address what is truly important—their needs. Next time you find yourself rushing through an encounter, remember to provide your patient that sip of water—it may be a word, a hug, a smile, a listening ear, or simply, humanism.

Natalia is a fourth year medical student at FSU College of Medicine Daytona Beach. She is originally from Miami, FL and



### Brent Carr, MD

### **3RD PLACE** • Humanism in Medicine Essay Contest 2022



### A BRIDGE BETWEEN LIFE AND DEATH

Jeanah Kim, MD, Class of 2022

As medical students the impact we have on the patients we encounter is greatly impressed upon us. Yet, it is the patients we have the privilege of meeting who mold the way we treat each subsequent person. During my OBGYN rotation I experienced one of the greatest joys in medicine, bringing new life into the world. I would forever be a part of someone's retelling of their birth no matter how small of a role I played. In some stories I was merely an observer while in others I delivered the baby and placed them on their mother's chest. With each miracle I was able to witness and participate in, I experienced the most humbling aspect of medicine. However, it is the loss of a 23-week baby that I most vividly remember.

I met this patient at her routine peripartum visit in the office. I went into the room, introduced myself and explained my role as a medical student. I would be measuring her stomach and her baby's heart rate. She welcomed me into the room, and we found easy conversation in discussing

how her husband, who was also a physician, had gone through the same program. She told me about his journey into medicine and how this baby was their first. I asked the necessary questions: "How are you feeling overall?" "Do you feel the baby moving?" "Any nausea/vomiting?" "Any pain?" She was feeling well with no complaints, no more nausea, vomiting, or pain, and she said the baby was very active and he had been kicking her last night.

As I reached for the Doppler and fumbled with the strings, she was kind and kept the conversation flowing. I walked over to her, helped her lie down, and placed the Doppler over her stomach. We kept talking about random things as I tried to hone in on the fetal heartbeat. It was only my second week, and I was still a novice. I couldn't get an accurate reading and when I looked at the monitor, I was getting a reading of 124, which is very low. I looked at her and reassured her that this was my second week, and I was still learning how to use the machine. I asked again when

the last time she felt the baby move and she reiterated that last night he was very active. Feeling more confident about her answer than my skills I left the room to give a recap to my preceptor. I retold the pertinent information and physical findings and he told me he would recheck the fetal heartbeat. He seemed calm and not too worried, so I felt the same.

We walked back into the room and he told Ms. A that he would recheck the fetal heartbeat. By this point in my rotation, I had seen the doctor quickly find the heartbeat on multiple occasions, but this time he took a little longer. He looked back at the patient and told her he was having a difficult time locating the heartbeat and this could be because the baby had moved, so we would use the ultrasound to check. As he told her this he was still calm without any visible signs of worry. She laughed nervously and we all walked to the ultrasound room. The lights dimmed and the monitor came to life. He pointed out structures and parts of the baby as they came into view. We looked at the baby, but then the doctor looked at me and I saw what he saw. The little valve of the baby's heart wasn't moving on the screen. In that quick glance I realized what this meant. The doctor gently put the probe down and held her hands. He told her that the heart of her baby boy had stopped and, based on the baby's measurements, it had happened within the last 24 hours.

Ms. A started sobbing. Loud and gutted, the tears kept coming. Her wails made my chest tighten and tears started spilling over my face. We stayed in that room feeling the heaviness of the news. The doctor continued to reassure her that she hadn't done anything to cause this and shouldn't blame herself. He continued to hold her hands and put his arm around her as she continued to sob. As the tears started to subside, he calmly told her that she would have to deliver the baby because of how far along she was and it would have to be done within 48 hours. The realization set in on her face and tears came out faster. He told her that for now she should tell her husband and they should mourn the loss but reiterated that they would have to make a plan soon.

After she left, my doctor and I sat in silence in his office. He finally spoke and said that medicine is a privilege filled with so many happy life changing moments, but the losses are often of greater magnitude.

Ms. A was admitted to the labor and delivery floor the next day. I went into her room and saw her husband there with her. She looked so defeated in the bed. As we talked

there was an emptiness in her voice and eyes, drained by the emotions she faced the day before. I quietly told her that we would induce her, there would be contractions, and we would be back to help. The day kept going, we went to clinic and delivered healthy babies in other rooms, yet the joy was less palpable. When we went back into Ms. A's room later that afternoon, she had been having contractions and was ready to deliver. She held her husband's hand and pushed. The pain of labor was the same as every other delivery, but the room was quiet. As the baby came out, he was perfect. He appeared like every other baby, just smaller. As the doctor handed him over to his parents, I saw the tiny fingernails on that tiny baby. We slipped out of the room and we heard the parents weeping as the door closed.

We came back a couple hours later and went into Ms. A's room. My doctor told her she had done nothing to cause this, to take time to grieve this loss, and he would be available to talk whenever she wanted. We left the room and he told me they had decided to cremate the baby and he had to sign the death certificate. We went into the small nursery the baby was at and he still looked perfect. As I looked at the small fingers and fingernails, the pit in my stomach that had been there from the first time I met the patient and every time after reappeared. This was another moment in the patient's life where I had played a part. It wouldn't be a memory that brought joy, but one that would always bring grief.

I saw her again for her two-week follow-up. We made easy conversation and she was kind. We went through the motion of the appointment but there was a sadness hanging over both of us. Following this process showed me the resilience and strength patients have when given heartbreaking news and the role physicians must take when helping patients navigate their decisions. This was the first time I was a part of a loss in this field. Medicine exists between life and death. As a future physician, we help others navigate the greatest joys and the greatest losses. It is a privilege that not many have, but one that always carries a heavy toll. This patient will always be the first loss in my medical journey and has influenced my understanding of the many roles physicians have for their patients.

Dr. Kim graduated from the College of Medicine in 2022 and is currently a resident in family medicine at Wake Forest Baptist Medical Center.

### FINALIST • Humanism in Medicine Essay Contest 2022

For me, humanism in medicine evolved through two clinical situations that I needed on my journey to become a better physician.

Alcohol, the delicious drink, ultimately took the life of the first patient I met on the hospital bed during my surgical rotation. I remembered spending countless hours studying alcohol-induced liver cirrhosis. Yes! I had it packed down: jaundice, ascites, bleeding, anemia, edema, varices, fetor hepaticus, melena, splenomegaly, etc.—the list goes on. I learned the pathophysiology of liver disease, but it did not hit me until I saw the 50-year-old female patient lying almost lifeless in the ICU. She did not have anyone beside her; both of her children were out of town. They were on the phone with my attending, having an end-of-life discussion to decide whether she would go to surgery or hospice.

I understood everything physiologically wrong with my patient, but the INTERNALLY emotion in the room was an idea far beyond my understanding. For a CRIED WITH moment, I forgot I was a medical student-it felt like she could have been my mother. When my HIM attending stated her chance of overall survival was very slim, it felt like I was stabbed in the heart. I cried when the patient's son said: Stenia Accilien, MD Class of 2022 "Please take her to the OR, even if there is a 1% chance of saving her life." Looking at the situation, everyone knew she was not going to make it. We took her to the OR. There, I retracted the abdomen as my surgeon searched for the source of bleeding, looking for the reason behind her deterioration. We found nothing. She was the textbook constellation of alcohol's impact on the body and, at the same time, a mother who could not see her kids before her demise. She gave me a better understanding of why I needed to be exhaustive when gathering social history, specifically about substance abuse. This also reminded me of the importance of motivational interviewing. I have now learned what alcohol does through books, and what it can do to patients' bodies and their families.

Before I knew it, I was on another rotation: psychiatry. There, I met the second patient who

would teach me the realities of mental health. I grew up in a culture in which mental health was almost nonexistent. Individuals with mental health illnesses were automatically labeled as "crazy." Psychiatrists were known as the people who take care of "crazy people." This seed of prejudice was planted into my spirit until I could truly understand mental illness through a patient I saw in my psychiatric rotation every day for five weeks. The patient changed my views, deepened my understanding of the effects of childhood trauma on the brain, and helped me realize the importance of treating all illnesses equally, whether it is cirrhosis or psychosis.

The patient was a 37-year-old male who was Baker Acted by law enforcement because he was found naked in his car with insensible speech. The only information on him was his van's decal that said "New

York." He had driven from New York to Florida and ended up at a

Fort Pierce psychiatric hospital. He had no other past medical or psychiatric information. When my attending and I first went to see him, the patient covered his head, stayed in his bed, and did not utter a single word. I was hoping we would have better luck on day two, but that was not the case. He showed no improvement the

whole week. He did not want to take any oral medication, so he received them intramuscularly.

In the second week, a social worker located his parents in New York. Per family, they had not seen him for two years since he divorced. He was diagnosed with bipolar disorder and was on lithium for a while. He stopped taking it, despite it working well. His family then traveled from New York to Florida to help him. When we finally met them, they seemed caring and were thankful for finally finding him. Eventually, they became over-involved in his health care and took his car back to New York without letting us know. They wanted him to go to the state hospital to maximize his treatment.

In the third week of his hospitalization, the patient interacted more with the staff. His illness started to show through his odd behaviors. For instance, some days, he would specifically request kosher

food, while others he would not. He requested to only speak to female nurses and staff. He would scream at the top of his lungs at night and sometimes remove all his clothing. He began accusing a security guard of assaulting him and demanded law enforcement do a full-body scan on him. After that incident, he was placed in his own room with no roommate.

In the fifth week of my rotation, I could finally thoroughly interview him. He gave me a glimpse of his childhood, culture, family, and upbringing, which made him who he is today. I listened and took notes, as would any medical student. He noticed and told me, "I know that you are listening to me because you take notes and have a very calming and positive energy. I feel safe talking to you." I did not know if his comment was real or was part of his own world. For the 45 minutes that I spoke with him, he let me into his view of the world. He told me about his abusive childhood, how his parents have narcissistic personality disorders, how he married a narcissistic woman who abused him and murdered his kids. He spoke of how she made him sharpen the knife that she used to murder the children. Suddenly, he started to cry, and I internally cried with him. Because although it was not actual reality, it was his reality. When a man cries in my culture, this signifies real pain, not just "craziness." Thus, this patient's illness was just as real as the patient's illness with cirrhosis. He deserved a complete social history, empathy, compassion, and understanding, just as any other medical disease. My challenge remained—how do I decide what is true from the patient's story and what is not? How do I reconcile the recommended task of always listening to the patient. I did not have an answer. His story was not reality, but it was his perception. The beauty of psychiatry is in its gray area, which allows for gathering a patient's story through words and actions, medications, and therapy. Just as we could pinpoint alcohol as a significant catalyst for the first patient's cirrhosis, we could pinpoint childhood trauma as a significant stressor within this patient's mental illness.

I grieve for these two patients, but I also am thankful. Because of these two clinical experiences, I now understand how to manage two extreme cases of medical illness. I am better equipped with a profound understanding of the unique interconnection between medicine in both its physical and mental form. With these two experiences, I have stepped out of science and melted with the humanistic approach to medicine. I felt empathy, pain, unimaginable loss, tears, and helplessness, which are all human emotions that

do not make me less of the physician I aim to be. I felt connected to them and imagined myself in different roles, allowing myself to feel those emotions and be present. When the time came to get to the next patient, I was able to start on a blank slate. I did all this, respecting my professional boundaries. I think of these moments as a time of professional and personal growth that I will always carry with me wherever I practice.

Dr. Accilien graduated from the College of Medicine in 2022 and is currently a resident in neurological surgery at the University of Arkansas College of Medicine.





### Hope Heldreth, Class of 2025

Skeletal fingers, labored breathing, and the sound of the steady drip of morphine. Holding my Auntie Bon's hand as more time passed between each breath, I thought, "Why am I pursuing a profession involving death?" Through my suffering, I thought back to my two friends who each lost their mothers to breast cancer when they were only 16. In some odd way, I felt closer to them, realizing that death is not the opposite of life, but rather the unique, albeit heartwrenching, part of life that unites us all. It's inevitable and unavoidable, but that's not to say hope doesn't have a place in the end of life.

How does my physician father do it? How does he look at a family and relay the news that nothing more can be done to rid their loved one's body of cancer, and then do it all over again? Growing up, I witnessed my dad coming home drained after talking to a newly-wed husband whose 32-year-old wife passed away from aggressive ovarian cancer, drained from rejoicing after relaying news of remission to a patient, and drained after summoning up all of his courage to tell my best friend that her mom would pass away within the week. I grew up surrounded by cancer and the way it affects all aspects of someone's life, including the lives of family and friends. While in my dad's office, one of his patients shared pictures of his daughter's wedding with me, remarking that, because of my dad, he was able to walk his daughter down the aisle. My dad handed me a thank-you note his patient's daughter wrote him. I had chills just looking at it, holding hope in my hands. This illustrated the importance of connecting with patients on a more personal level-medicine is as much about recognizing the life and the person behind the diagnosis as it is about treating their illness.

Could I handle the amount of sadness and death that comes with oncology and similar professions? My opportunity came at Massachusetts General Hospital when Dr. Jimenez had me see a patient on my own. She was an 84-year-old woman with ER-negative, PR-positive, Her-2 negative, grade 2 DCIS. There I was, a mere 20 years, with only two years of undergrad education under my belt, given the responsibility of being the first face a patient sees

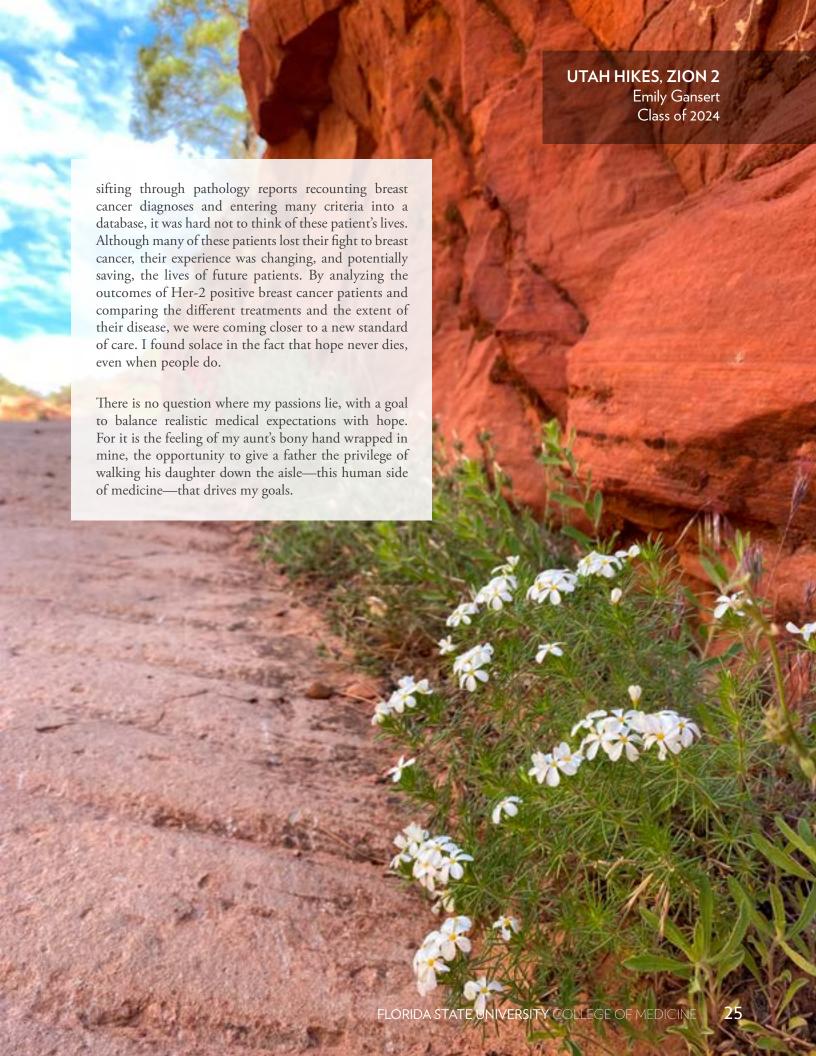
### DICINE

after her fateful mammogram.
Applying the little

knowledge I knew of proliferating cells and the hormones that fuel them, I explained her diagnosis on the basic level to which I understood it. The "meat and potatoes" of breast cancer, as Dr. Jimenez likes to say. Seeing the worry between her eyebrows ease, I realized that while my knowledge could not inform medical decisions, it did enable me to connect with the patient on a level she would understand. This experience taught me a valuable lesson: to never lose my ability to empathize and connect even when I eventually gain the knowledge to prescribe treatment plans and medical recommendations.

However, this was an easy conversation, no death on the horizon. What about the hospice conversations, the hold on to hope conversations, the "there is nothing more to be done" conversations? Throughout my college years, I lost two aunts, an uncle, and my beloved Nana. Experiencing the end of life first hand led me to apply to Seasons Hospice. I paid weekly visits to two patients during my time volunteering. The first was a 97-year-old woman who wanted to reminisce about life and offer wisdom. The second was an 86-year-old woman who expressed her excitement to go to heaven. While one patient reflected on the past and the other looked to the future, hope and gratitude were at the forefront of every conversation. Being a witness to death personally, medically, and through hospice care has impressed upon me the importance of guiding people out of the world with as much dignity as you introduce them to it.

If cancer, hospice, and palliative care often end in death, where does hope fit in? Of course, there is always hope of remission from cancer or cure from a chronic illness, but this sense of hope for one's legacy, as I learned in hospice, led me to discover that hope also exists in research. While





### The Thirty Minute Encounter

Narjis Mhaimeed

I walked in.

The beginning:
a slender man
with tired eyes
revealing his south asian descent.
Fatigued,
moaning in pain.
My patient,
he goes by Bhuwan,
with suspected Crohn's disease.

He soon spoke about Nepal

like he was living there in his mind

A thirty minute encounter.
A language barrier between us,
communication with only a few words.
Both of us dearly struggling to understand each other,
but enjoying it nonetheless.

and new life breathed into him:
A soul awakened.
I was almost there,
in the mountains with him
amongst the clouds.
The rush and noise of the corridors suddenly deafened
and we could only hear the birds flying above
through the fog.

It was my time to go. I waived goodbye.

"And your name?" he asked.

Narjis, I replied.
"Your country?"
Syria, I responded.
And then I wondered,
none of my patients had asked for my name before,
none of my patients had asked where I am from.
And then I realized,
I have never given them a chance to ask.

Tender smile, curious nature. Human. My friend, he goes by Bhuwan,

"You come to Nepal?" he asked. One day I'll come and I'll visit you, I replied.

with a life far beyond the curtains of his hospital bed.

The cure already began, even before the diagnosis was confirmed. I left the room. A bittersweet ending.

Narjis Mhaimeed is a 4th year medical student at Weill Cornell Medical College in Qatar. She has a passion for literature and the arts, which she hopes to incorporate into her future medical practice.





**FEMALE ROLES OF ENGAGEMENT/WEAVING HOPE FOR UKRAINE**Nancy Jane Lee Jones

Nancy Jane Lee Jones is a mixed-media artist working in the rural Florida panhandle. Her work focuses on women, probing and reflecting on issues of gender in the recorded narrative.





# the

Leah Genn, MD

"Rituxan."

She said the medication name as if it held her hopes, dreams, and the potential for a miracle all in one three-syllable word. Her three children and daughter-in-law grabbed hold of the idea immediately, desperate for an option that did not feel like giving up. An infusion that could bring their mother back to their beloved New Hampshire, and as far away as possible from the Sarasota vacation that had quickly turned from paradise to nightmare.

Here was an 86-year-old woman whose husband called her his "muffin." A woman who was adamant about heading to the beach town she'd heard so much about before she would no longer be able to travel. Who convinced her children, after much cajoling, to enjoy a few days off as well. Who had bravely fought off rheumatoid arthritis-associated interstitial lung disease for over 5 years with a twice-yearly infusion of a monoclonal antibody.

The treatment's success over the years led her to believe she had many good ones left. More time with her beloved husband of 64 years, living in a small apartment on their expansive farm, on the road that shared their last name and where generations of their family had prospered. More fun with her ten grandchildren, who visited several times every week, and who had children of their own on the way. More laughs, more jokes, more love.

More, more, more. Just a little bit more, was all she was asking.

Instead, a pesky but seemingly insignificant bout of COVID-19 had popped up a month earlier, from which she had not been able to fully recover. She got on the plane anyway, hoping to focus on relaxation rather than the bothersome winded feeling that kept creeping up when she exerted herself a little too much. She continued to go on walks, head to the beach each morning, and even swim a little before she started gasping for air walking from her hotel bed to the bathroom.

Next came an ER visit for much-needed oxygen that morphed into a hospital admission for steroids, antibiotics, and consults to explain her bizarre imaging findings. Hours turned to days turned to weeks. Nasal canula, to high flow, to OptiFlow. A roller coaster of new treatments, improvements in her oxygen saturation, only to worsen right as her doctors were planning to discharge her. Her children returned to New Hampshire, only to drive back down with an RV, in the hopes they would be able to transport her back home themselves.

Enter the Supportive Care Services team, called in by the primary hospitalist after three weeks and significantly increased oxygen requirements, the hope for a potential discharge growing dimmer each day. Named "Supportive Care" because "Palliative and Hospice Care" was sometimes too much for a patient and family to hear on an initial visit. While her children were still in town, she repeated her desire for Rituxan to every new member of her care team, hoping to reverse her lung damage and get back home to her husband. Always thinking of others, she urged her children to return up north, back to their own families and jobs in the meantime.

Alone, she had time to think about her life and the time she had left. She was just so, so tired. Of fighting for every breath, of seeing the concern and anguish on her family members' faces, of the seemingly interminable wait to see if a new treatment might finally improve her ability to breathe.

So, she and I talked. And planned. And envisioned every possibility, together. Not to give up, but to change the fight: no longer for a cure, but for the comfort she deserved. Our hands so tightly wrapped around one another's that we couldn't tell who was holding up whom in that moment.

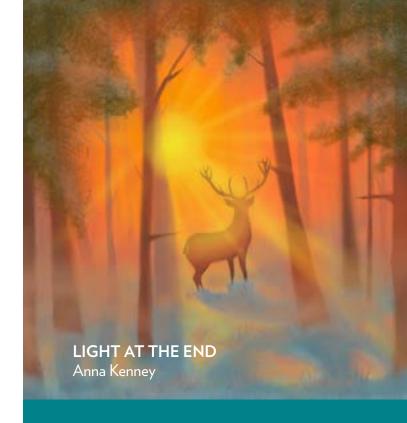
Our vocabulary gradually changed, too, over those next few hours and days. From machines, treatments, and cures, to comfort, relaxation, and pain relief. To

# FIGHT

maximizing her good moments and planning ahead for the bad ones. To decreasing the incessant noise of a hospital room—the beeping, whirring and clacking—and the seemingly constant disruptions from nurses and doctors. To freeing her from the loud, tireless OptiFlow that had been her companion and lifesaver for the past week and a half. Reassuring her again and again that keeping patients as comfortable and pain-free as possible was Supportive Care's bread and butter. And the very reason this resilient, passionate, and compassionate team got up every morning.

She picked Saturday as her day of freedom. From the machines, the anxiety, the pain. And in return, she got minutes to hours with her family, intentional and undistracted, lucid for however long the morphine and her rapidly building carbon dioxide levels would allow. She left behind three children and a daughter-in-law, who she claimed as her fourth, beloved like all the rest. A husband, too frail to travel, who said his goodbyes over a screen, sending her off with his love. And a medical student, humbled and honored to have been able to help honor her last wishes. A life well lived, and an eternal rest most deserved.

Leah Genn, FSU College of Medicine Class of 2022, is a first-year resident at the Lawrence Family Medicine Residency Program in Massachusetts. She is grateful to learn and practice the art of medicine alongside an incredible group of co-residents and faculty, humble herself even further while learning Spanish along the way, and survive her first real winter.



### **Dust**

Sean Gabany Class of 2025

After this moment, you'll never be this age again. So what to do now? And what then? "Live life fully." But what is full? Is it excitement in the everyday? The little things that people say? Is it going off with your friends? Breaking free from society's mold? Or is it making sure you're remembered, when you're finally old? When the time comes, can we look back at our jubilee or will we be trapped, by our own misery? Does it matter? Does it really? When we are one with the Earth. when in this world our mind has no turf. But what if we do remember? What if there's more? Cursed to never have this answer, so with life do we take a chance, or

not even bother.

### **Irinotecan**

### Martin Rodriguez

Irinotecan is indicated as a component of first-line therapy for patients with metastatic carcinoma of the colon . . .

Your name sounds like some ancient Mayan God stone-faced glare bleached hot white in Mexican sun demanding sacrifice, fragrant blood of dogs, deer, wild turkey or humans, children, even my sister, who calls me crying like the child she once was.

Your high priest,
Dr. Amin, a merciless man
assembles his patients
in his chemo room,
pours you slow into veins,
denies your side effects,
the way you make my sister bleed
from her heels, fingernails, toenails,
make her a martyr with this
chemotherapy stigmata.

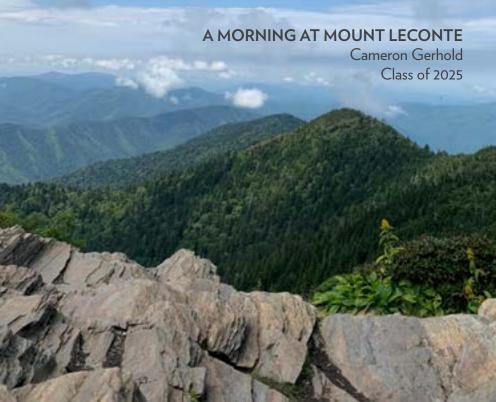
Even her brain is bleeding.
The surgeons drill holes
in her skull to drain it out.
She looks like the queen
of the *Borg*, tubes coming
out of her head while she walks
through the hospital ward
with her paralyzed stare,
overhears the nurses whispering:
"No one makes it
out of this ward alive ..."

The pact I made with Jesus was useless—her cancer has returned. Now my prayers are rage, threats, what kind of God have I been praying to?

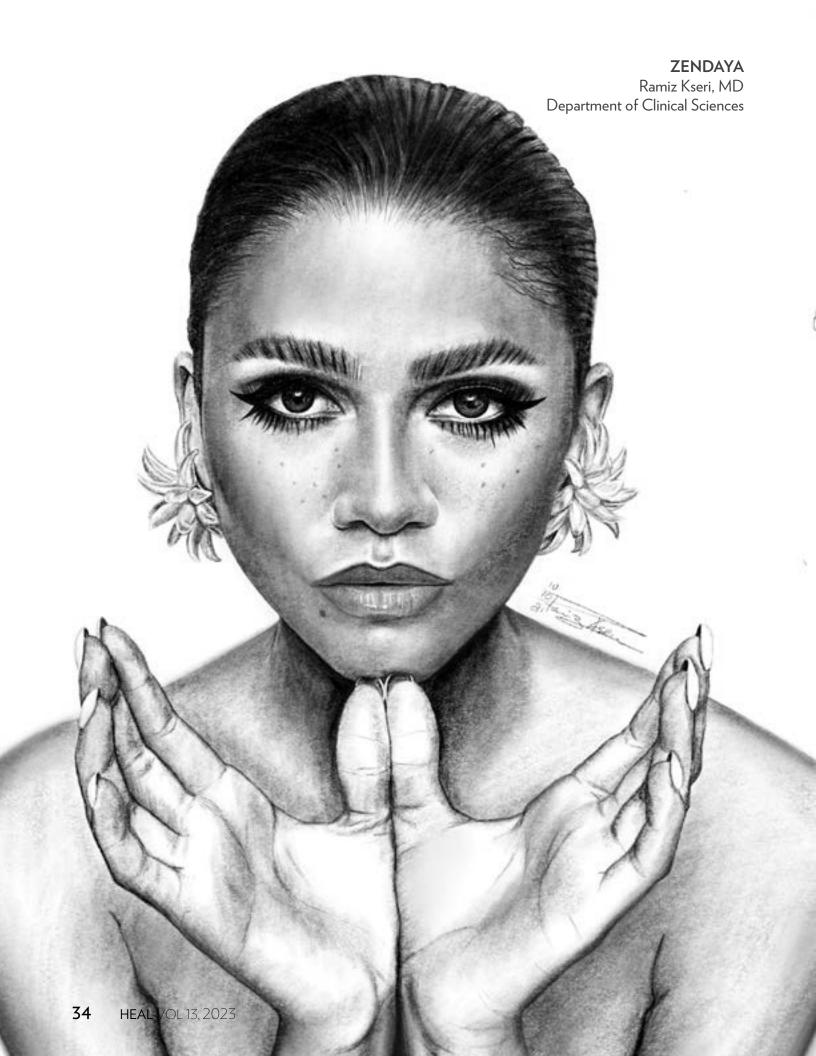
Martin Rodriguez's poetry has been on exhibit at Boston's City Hall and published in the Paterson Literary Review. He lives in Quincy, Massachusetts.







**FALCON 9** Logan Malter





### **IN A DARK PLACE**

Louis Gallo, PhD

When everything became irrelevant so suddenly I noticed in my back yard a sagging rose vine, a vine that had produced roses for us for decades.

Full of buds, it hung limply, drooping over to the ground. I retrieved an old, dusty tomato stake from the shed, pounded it into the ground with a hammer and, sturdily beloved, lifted the vine such that its tendrils curled around the stake. I raked leaves and debris from its base, yanked out weeds—difficult for me because it required kneeling and bending, not so easy when your chakras need oil.

The bush, about to burst into bloom, seemed happy, and I was happy because it now looked so pristine and vibrant against the Quaid fence, cleared of all irrelevancies. And as I worked to restore that old friend, I forgot all about the darkness that has recently ransacked all of our minds and learned that irrelevance is irrelevant.

Dr. Gallo is the author of the following poetry collections: Archaeology, Scherzo Furiant, Crash, and Clearing the Attic.

Dionne Blake is a third-year MD/MPH student at the University of Florida College of Medicine, class of 2024. She enjoys drawing, photography, weightlifting and spending time with friends in her free time. This photo was taken at the Vizcaya Museum in Miami, FL.

### Nostalgia Agonistes

Louis Gallo, PhD



#### for my daughter

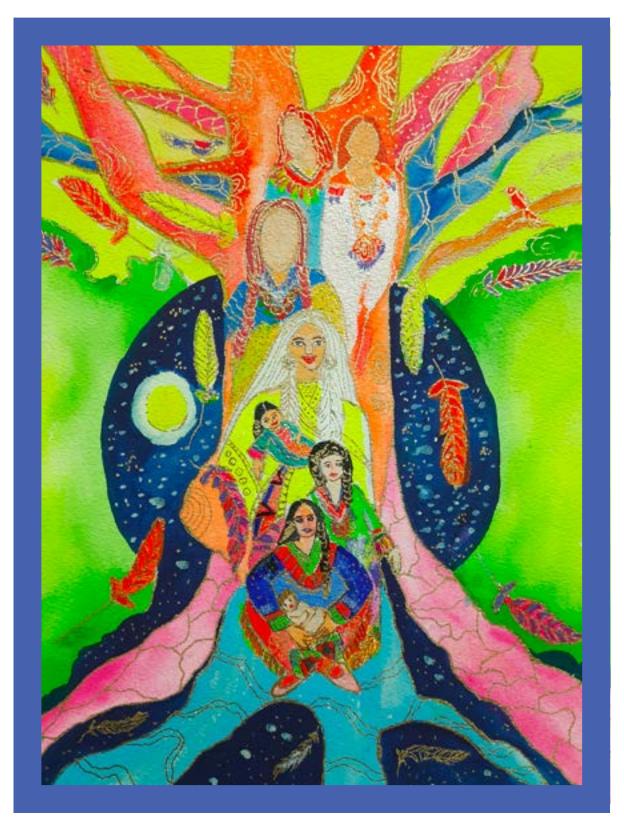
As I walked out last afternoon by the tracks as usual leaves fluttered in the wind, yellow fan-shaped ginkgo leaves, with my daughter and our dog I heard her exclaim, gushing so, her admiration for those leaves, so beautiful, she said as she snapped a photo of the barren tree from which they had all fast abandoned.

But now it's I alone on the walk and beholding those leaves asunder spread I squatted down to gather three (though bending for me is difficult) stored them in my jacket pocket and meant to present them to her when I drove back home from the tracks. I wanted to surprise her with tokens of the beautiful.

But one exigency after another and I quite forgot the leaves where they remained in that pocket until much later in the eve when upon an instant sudden I did remember and made a point of delivering them to her as she studied on the couch.

Awww, she said, and touched them gently, the smile on her face bounteous...
I smiled too though my heart rue-laden over memories further back, that accumulation, that wracking load... to think this is how we thus prosper, gathering ephemeral blisses when we can to offset the anvil of time and its hurricanes of ruin.

I chastised myself for dark forebodings that served to nullify the moment when she and I smiled together over three yellow ginkgo leaves. To think that we can allow ourselves remorse amid pure rejoicing, surely, surely, we've missed the point. Nostalgia for the previous moment, imagine that, imagine that.



**LIFE**Chaitali Hambire, MDS

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



Dr. Islam (Class of 2021) is currently a 2nd year psychiatry resident at Mountain Area Health Education Center (MAHEC) in Asheville, NC.

#### "I don't want to be alive anymore."

My friend Margot was despondent. Her lips quivered. Her eyes, normally the shape of almonds, folded themselves into little triangles when she cried. This kind and gentle woman of 62 years — my neighbor — was undeniably at her lowest point. I was sharing a couch with her during my junior year of college as her composure crumpled before me.

I first met Margot when her companion, a dog named Sofie, ran loose and I helped reunite them. When I saw her — a slight woman with wispy brown hair, empty leash in her hand — she clutched Sofie like her own daughter. "She is all I have, all I have," she cried. Her apartment was small, dark, and brimming with unopened cardboard boxes. The scent of wine lingered in the air. Our new friend needed some help adjusting to Los Angeles.

Following a nasty divorce, Margot felt lost. I listened to her stories about growing up in France and, as the years passed, she bore witness to the realization that I wanted to go to medical school. I took her to urgent care, veterinary appointments, the visa office downtown. She showed me Jewish music. She met my family. She was a brilliant woman.

But many of her problems – immigration, depression, drinking – were not easy fixes. I was scared of her trauma. Scared of setting off her tears. Scared of probing too deeply about her son, who she desperately messaged on the days she felt saddest, receiving only silence.

Three years later as I prepared for my psychiatry rotation,
I remembered being the college student

who realized she bit off more than she could chew. I was nervous. Some say the more intimate medical specialties are surgery and psychiatry. Surgery, my third rotation, struck me as concrete and precise in its handling of the body. I retracted bowel, closed skin, felt a woman's pulsating aorta and spoke to her the next morning. Intimate indeed! By comparison psychiatry seemed abstract and imprecise, like surgery

in the dark. I imagined myself striking exposed nerves without my knowledge: saying the wrong thing, offending someone, hearing my voice echo back at me from caverns I was too afraid to enter.

Margat

Allison T. Ong

My first encounter on Child Psychiatry was a girl who swallowed a handful of pills. I nearly shrunk into the curtains trying not to betray how terrified I was by a psychiatric interview. Yet I saw how confidently and compassionately our psychiatrists handled her story, responded to her emotions, and drew out the pertinent aspects of the history allowing them to identify what she needed most.

These were the conversations I wanted to learn about.

--

Navajo surgeon Lori Arviso Alvord wrote in *The Scalpel and the Silver Bear*, "the scalpel is used to bridge worlds." Dr. Alvord carved pathways between Navajo culture and white culture, between air outside the body and air within the body. She practiced surgery in the concept of *hozho*, walking in beauty. The surgeon in harmony with her team, her patient, and her world: *hozho*.

I imagined psychiatrists wielding a scalpel of their own. One of my first patients was a slim, pale girl hospitalized for a serious infection. Her history included autism spectrum disorder, depression, anxiety, and PTSD. She was extremely intelligent, with a quick and dry sense of humor. But she became nearly unresponsive when probed about her family. I wanted to build a bridge.

My favorite professors challenge us to hone our observational skills. Between images of chest X-rays and angry rashes, one professor presented an ordinary photo of our campus and heightened our awareness to a hummingbird nest (with babies) hidden expertly in the beams of a light fixture. Another professor had us analyze paintings exploring pain. The artist in me had always wanted to sharpen this awareness in a medical lens. So in my patient's room I let my gaze wander: over a monthlong stay, what had she filled her space with?

Books for learning Japanese, colored pencils, a Pokemon plushie... so she played Pokemon, which I happened to be familiar with. I have one more question for you, I said at the end of our first meeting. Who was your starter Pokemon from the Sinnoh region?

Her eyes lit up.

Although this girl struggled with her own emotions, she excelled at crafting stories for animated characters. So

I challenged her: each day, she chose a Pokemon that represented her mood. At first every Pokemon she chose was "tired." But after a couple sessions she picked one that looked "sad," and we explored that. When she meditated with the help of my classmate, she shared a peaceful memory with her family.

She was also a gentle introduction to the many visits I took in the ED for suicidal ideation. I pictured myself on the couch next to Margot, afraid, and then reminded myself how far I'd come. My fellow coached me, "when you stay calm and confident, your patients will open up seeing that you can handle it." So I took my deep breaths. I learned how to let the patient drive their story and tried my best to find what they needed next, even if it was a million things they really needed. There was no rush, no race. Our goal was to build bridges and invite people across.

--

Margot returned to France, looking to turn a new page in her story. There's still so much sadness in her I don't know how to handle, but if there's anything medicine has taught me yet, it's that we will learn and grow throughout our entire lives. Part of that learning includes setting boundaries.

It's a rite of passage for students to see every field and challenge themselves into the doctor they want to be. The gravity of difficult questions stays with me as I continue to ask them in different forms, in different settings, to different people.

But what is gravity if not grounding us with our patients, with ourselves?

Allison Ong is a fourth-year student at the UC Davis School of Medicine in Sacramento, California. She is applying into Internal Medicine-Pediatrics due to her interests in chronic illness care across the lifespan. She is also passionate about creative writing, drawing, and illustration. "Margot" originally appeared on KevinMD.



## THE THING WITH FEATHERS Matt Johnson

Matt Johnson is a 3<sup>rd</sup> year medical student at the University of Florida interested in treating pediatric cancers. His artistic interests include the intersection of arts and medicine, color theory with natural elements, and hope in medicine.



**PENITENTIARY**Michael Hayward

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

## After the Ultrasound

Julene Tripp Weaver

The ultrasound is normal, but this poetic phrase, *your pancreas* is *unremarkable*, evokes a smile

an interpretive dance to feel so alive despite warnings of my demise.

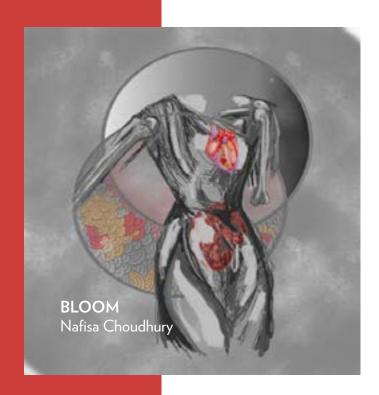
On meds since 03, after that first Shingles infection, T-cells below fifty, I wavered

my body an experiment, willing to surrender, to risk my own science, doctors blind to my methods

of survival—what I choose not proven on their bell curve—but after these many years stable,

now this sudden aberration, liver and kidney blood tests elevated, with no reason.

Julene Tripp Weaver is a psychotherapist and writer in Seattle; her third poetry book, Truth Be Bold—Serenading Life & Death in the Age of AIDS, was finalist for a Lambda Literary Award, won the Bisexual Book Award and four Human Relations Indie Book Awards.



Dr. Choudhury is a first year resident in psychiatry at the University of Florida. She is particularly interested in the intersection between visual arts and medicine and the commentary this interplay provides.

# IT'S KIND OF LIKE Sydney Cabana





# **ORBIT AND ITS INFLAMMATORY TRAJECTORY**Pankaj Goyal, MD

Dr. Goyal is a surgeon at the Apollo ENT Hospital in Jodhpur, India.

Artist's Statement: This painting was inspired by my work as an ENT surgeon who regularly deals with orbital inflammation pathology. In the human body, the orbit is the bony cavity in the skull that houses the globe of the eye, the muscles that move the eye, the lacrimal gland, and the blood vessels and nerves required to supply these structures. In the solar system, each planet and its satellite have its own trajectory pathway, known as "orbit." Deviation is disastrous. In this current COVID situation, the fungus Mucormycosis creates similar havoc in the human orbit. The orbital content gets inflamed, and if not treated properly, also leads to disaster. Special thanks to Dr. Manisha Chouhan for the inspiration.

# KAIRASI

## (HEALING HANDS)

Anna Rachel Menezes, MBBS

"Ungalodh kairasi nalla irkude," said Thatha\* as I dispensed his discharge medications while diffidently stuttering instructions in Tamil. He handed me a kilogram each of sweet potatoes and custard apples, homegrown from his farm, 100 miles away. After an initial spur of hesitation, I accepted it with a thankful smile, remembering that the administrators who supervised the hospital had advised me to receive produce as a form of gratitude from patients. Vendibles were not only a means of living but also a sign of growth and prosperity. Members of the household traveled long distances to procure them for a doctor, and turning them down meant rejecting the fruits of their hard-earned labour.

While distributing my newly acquired produce among the hospital's healthcare workers, I sheepishly asked a nurse what "*Ungalodh kairasi nalla irkude*" meant. I was afraid it would mean, "I was expecting better" or "Your treatment could have been more economical," phrases that were not uncommon at the various corporate hospitals I interned at a few months ago. She giggled and said that it meant "you have hands that heal." Funnily enough, I beamed with joy! Thatha's treatment plan wasn't extraordinary—a short course of diuretics, compression bandages, and lower limb elevation for his heart failure-related edema. I was pleasantly surprised that my hands could earn amiable compliments from patients they barely touched.

A few days later, I was called at 10 pm. A cobra had just bitten a 14-year-old girl. While I answered the call, my eyes couldn't help but reflexively catch a glimpse of my phone's calendar widget counting down to a coming medical licensing exam: "December 29th: 10 days." Fraught, I tried pushing away my anxiety as hastily as I put on my white coat. I remembered what Ma had said, "Put your patient first; everything else will find its way." A glimmer of hope that maybe I'd find a question on cobra bites that would give me an edge over the million other doctors writing the exam.

V was plucking flowers to trade at the local *santhe* (market) when the cobra (ironically called *nallapaambu*,

or nice snake) bit her. She seemed stable on arrival, but a month's experience had taught me not to jump to conclusions, especially when there's a *nallapaambu* involved. While taking a brief history before jotting down 10 vials of anti-snake venom on her order sheet, I asked her what could cause her to pluck flowers this late into the dark night, completely forgetting that flowers wither and the freshness of her posies at 5 am the following day would determine the income her family made.

Four hours later, I carefully examined her for any signs of envenomation. P-D-D, my mind repeated instinctively as I searched her for signs of ptosis, diplopia, dysarthria, and difficulty in breathing. She had none, an alleviating sigh of relief for me and the only nurse on night duty. I helped her move to the stable side of the ward and quickly trotted up the stairs back to my study with the help of my firefly attracting flashlight. Although night time in the village was eerie, it gave me a heightened sense of focus that allowed me to study, and the last 4 hours of adrenaline could keep me going for a while.

December 29<sup>th</sup>: 9 days, I glanced at the widget again before my phone unexpectedly chimed with the ringtone I'd set for hospital calls. A sinister chill ran through my spine. A ring at this time could only mean something was wrong with V. I found myself running down the cement stairs without my flashlight and half buttoning my lab coat, only to encounter the worst I had seen.

V had been shifted back into the treatment room with her parents holding her, one on each side. She couldn't move her arms, and her eyelids had begun to droop. The sharp-witted nurse had adeptly brought her back, knowing these were not signs of lack of sleep. As she and I began to load V's ongoing fluids with higher doses of anti-snake venom, her parent's anxious eyes were struck with a terror I was not accustomed to. The fear of possibly losing their only daughter. A daughter who went out of her way, after a tiring day at school, to help

her parents pluck flowers. A daughter born after many years of a barren marriage, a daughter her parents had grown to love increasingly as days passed and. . . Before I could return to loading the drug, I found V's mother had dropped to the floor due to vasovagal syncope. I had to continue loading the drug, given the rapidly frightening situation. While instructing her husband to move his wife into the waiting room and elevate her legs, I asked the nurse to load neostigmine—a drug that I had only "heard of" in medical school.

V's father returned in a few minutes, nervously asking if V would need to be moved to a higher medical center, recalling what we had stated while counselling him for her admission. The nearest hospital was 40 minutes away, and 40 minutes without a ventilator could mean much worse. "I'm afraid the nearest hospital is too far to take a chance," I said, injecting V with the loaded neostigmine. Although I put on a tough exterior, I was dubiously trying to reassure myself that I could handle my patient.

After injecting V with over 20 vials of ASV and 4 doses of neostigmine, the murky night started to clear. Her eyelids no longer drooped, and she could follow my commands. She would have to be closely observed for any further signs of envenomation for at least two hours, which happened to be the time I had before the outpatient department opened. I ran up to the study, pulled my worn-out textbook, and returned to place a stool in front of her and examine her every 10 minutes while rummaging through images from the book. "What are you reading?" she asked. "It's nothing much," I said, swallowing the guilt that I had used the first 3 months of my monthly stipend only to apply for the exam. Still, a conversation between a doctor and a patient slowly turned into one between two young girls with big dreams and ambitions, exams to write, friends to meet, and parents to help.

I wondered if my exam refuted the aim of making me a better doctor. If I made the right choice by serving in a rural hospital far away from home. If it was fair that I had to compete against doctors who didn't have these opportunities. And if I could reach higher levels of assertive thinking if I did not have an impending exam to write.

Three days before my exam, I informed V's parents that I wouldn't be on the hospital premises for the next few days and that they would have to notify the nurses

immediately if any issues arose. Unsure if they could gauge the apprehension in my eyes, I sought their blessings for a proficient result.

At dawn, before I left, V gave me a bunch of fresh ripe bananas that her brother had procured from the field. "Don't worry, doctor," she said, "*Neengal nalla panvinge, ungalodhu kairaasi nalla irkude*" (You'll do well because you have hands that heal).

\* *Thatha* is a term of endearment for an elderly individual in South India.

Dr. Menezes is a graduate of St. John's Medical College, Bangalore, India. She has completed a 2-year service as a medical officer in rural southern India and currently plans to pursue a residency in radiology.



**BLOOM WHERE YOU ARE PLANTED**Kayla Smith and Nick Thomas

Kayla Smith is a licensed social worker in Denver, Colorado, who loves to create art whenever she can.



# Cento For My Younger Sister With Multiple Myeloma

Julene Tripp Weaver

There have been monsters under my heart since I was born. You see, I had no sister when I was little a dove that nests in Paris's walls has warmed a cuckoo's egg—

I am in her like dust in a tornado, night in a star, ice in a glacier. I love my sister I need my sister to wade in the dark night water,

to sneak in and out of back doors saying the spell under my breath that no life is slight enough to pass How "Fuck you" becomes a love song

I predict that losing you, specifically,
will be too much to bear. You are a species
that knows it will go extinct,
This is how I will let go of loss,
by carrying you with me,

after a hug, the between is holdable, fortune tell a sense of longing and loss I cannot love without a sister I whisper How long do we have? to no one in particular

Note: A cento is a poem composed entirely of lines from other poems. This compiled chorus consists of the following voices: Devon Miller-Duggan, Jennifer D. Brock, Samantha Pious, Kristina Morgan, Sadie Dupuis, Courtney Lund O'Neil, Aaron Wander, Bethany Reid, Aracelis Girmay, Sarah Vapp, Christina MR Norcross, Sarah Dickenson Snyder, Kai Coggin, Rilke (translator Bly), Joan Kwon Glass.



TRICOLOR Michael Hayward

# AHUG

#### Christopher D. Busack, MD

Dr. Busack is a current pediatric cardiac anesthesiology fellow at Children's National Hospital in Washington, DC. My medical school personal statement was far from unique. It included fiery, spirited lines about making a meaningful difference in people's lives. Although patient's lives have certainly been changed during my short career, the long hours and burdens of training slowly, but surely, begin to extinguish that fiery spirit. I am not immune to the burnout phenomenon that is all too common in medicine, and despite various institutional wellness initiatives, my psychological state hindered my ability to perceive the positive impacts of our profession. One morning, my funk was abated by a simple act of human connection when a little girl rekindled my spirits with an unexpected hug.

I introduced myself the same way I have all year, expecting my preschool patient to greet me with indifference or skepticism. Instead of staring or crying, the five-year-old girl standing just barely 3 feet tall ran right over and gave my legs a big hug. Her eyes merely reached my belly button, so it took her a moment to look up and see the only part of my face left uncovered by a mask. I think she could see the emotions within my eyes, so she quickly distracted me, taking my hand and pulling me over to show me her frog stickers.

Why did a five-year-old's hug turn my insides upside down? Well, the night before her surgery, I read through the patient chart just like all good anesthesia trainees do. This time I was faced with what so many of my advisors warned me about a career in pediatric anesthesia. As colorful and decorated as a children's hospital can be, there are some awful stories found within patient histories that require thick skin. Her chart revealed that nearly a year earlier, she was admitted with a traumatic brain injury necessitating a decompressive hemicraniectomy. The cause was non-accidental trauma.

Based on the neurosurgery notes, she had a prolonged hospitalization with repeated trips to the operating room for wound and shunt revisions. Her cranioplasty had been postponed a few times due to legal issues and care coordination. But according to the notes, she was now neurologically well and ready for a cranioplasty. Despite the horror of her past, she was the happiest five-year-old I'd ever seen. Unlike most of her peers, she was properly wearing an N95 with a pretty purple cloth mask over the top of it – each one properly covering her nose and mouth. She had a beautiful relationship with her foster mother, and quickly fostered the most meaningful doctor-patient relationship of my young career. The previous night's preparation framed my heart for sadness. So, when I was met by a room full of gladness and an adorable little human greeting me with a big hug, my preconditioned heart didn't quite

know how to respond. Luckily the five-year-old distracted me with cool stickers before I could shed a tear.

In the 30 minutes it took for her same-day COVID test result to come back, we played in her preop room. Her foster mom had clearly prepared her well. She knew that she took her medicine at 5:00am, and she knew that she would be going to sleep by breathing anesthesia gas. Instead of fearing the operating room and doctors, she was curious and motivated to breathe the correct way.

"Should I breathe like this or that? Should I put Elsa on this side or Spiderman on that side of the mask? Can we go now? Can you show me a different room? This one is boring. Do you have more stickers? When can we go?" she asked barely pausing for silence. Eventually, I was able to answer, "Sorry we have to stay here for 10 more minutes, but I'll go get you more stickers." I returned with some more Disney characters, and we soon fully covered her plastic mask. When it was time to walk back, she chose to test drive the little red racecar pushcart instead. Unsurprisingly, she buckled the seatbelt without me or mom asking. I pushed her down the hall talking about the frog, fox, and turtle posters on the wall along the way. In the operating room, she quickly unbuckled and began exploring. After nearly contaminating the instruments, she eventually jumped onto the operating table. I asked her if I could remove her N95 and swap it out with the completely stickered plastic mask. She let me, but at the same time educated me that her mask was there to protect herself from the coronavirus just before the bubble gum-scented sevoflurane sent her off to sleep.

I was taught in medical school that it is our privilege to take care of patients. They are the ones who teach us, and we should thank them for allowing us to care for them. That morning, my five-year-old taught me more about resilience, happiness, and curiosity than any professor ever could. If this little girl could laugh and smile after waking up before sunrise for brain surgery, then how could I let burnout distract me from experiencing the beauty of our profession? Her recent

memories were filled with the most traumatic experiences I could ever imagine, and the biggest pandemic of our lifetime, but still she was nothing but happy. I'm not so naïve to think that burnout won't creep up on me again, but luckily, I chose a profession where I might just meet another resilient five-year-old around the corner happy to offer me a hug.



# **PISCES**Beth Appleton

For the past 30 years, Beth Appleton has created in her studio home on the Gulf Coast of Florida, a place of boundless inspiration.





# THE BUNION

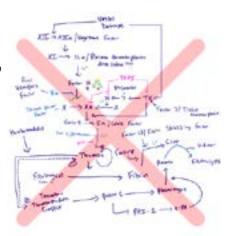
## **BREAKING NEWS!**

# Coagulation Cascade Made Up, Group of Medical Students Claim

Silas Helbig & Steven Latta Florida International University

Miami, FL - A group of medical students are claiming to have uncovered evidence hidden deep within the archives of the National Library of Medicine which they say proves the coagulation cascade has been a scam since it was "discovered" over 100 years ago. The students were inspired by a TikTok made by world-renowned ophthalmologist, Dr. Glaucomflecken, where a guest hematologist admitted to the coagulation cascade being fake. For those who are not in the medical field, the so-called "coagulation cascade" is a series of reactions which supposedly help you stop bleeding; I personally just use a bandage.

After extensive research of the evidence, the students claim that academic hematologists put this theory in place to make themselves look smarter than the other medical specialties, just by being able to remember a bunch of random numbers. We asked the medical student leading the charge against the coagulation cascade about this discovery and what led them to take on the field of hematology. Here is their response, "I just knew it sounded fake when they started using roman numerals and they did not even go in order. Like who does that?" The movement is growing among medical students nationwide as more are calling for its removal from the medical school curriculum.



A nice concise diagram of the coagulation cascade – Artist does not take responsibility for any "inaccuracies" in this drawing as more steps may have been fabricated

Interestingly, in an independent investigation by The Bunion, a search in the PubMed database comprising more than 34 million citations yielded zero results when "coagulation cascade fake" was input as a search term. Coincidence? We think not, and we encourage you to search yourself. This may be a level of medical censorship unseen since the cover up which hid evidence of the mitochondria being the powerhouse of the cell. After hearing this story, The Bunion team immediately flew to Miami to interview these brave medical students putting their professional future on the line. Below are some highlights from our interview with the team leading what they call, The War(farin) to (Xa)ban the coagulation cascade from medical education.

This is a developing story, please check back once more facts about the case are gathered and crosslinked to form a stronger mesh of evidence.

#### COI statement:

The authors of this article report no conflict of interest other than the team of medical students paying them \$1,000,000 to write this column. (We do not know where they got this money either, but we also did not ask any questions after the check cleared.) We also would like to thank the Pro-Platelet Association of America for graciously offering to edit this article for us free of charge.

"We found out that each hematologist just kept adding more coagulation factors to the cascade, and it just kind of got out of hand. This hubris has allowed us to see how obviously fake and made up the whole thing is." —Jonathan Bloodsworth, M4.

"Coagulate? More like Coagu-gate, this scandal is going to be bigger than Watergate, which does not have a coagulation cascade either, the last time I checked." —Luke Emia, M2.

"This is clearly an attempt by big medicine to further torture medical students into learning about something that is so complicated it obviously cannot be real." –*Kap Hillary, M1*.

"I would prefer the LCME act swiftly to denounce the coagulation cascade and remove it from medical school education. My Step 1 exam is next month and I cannot bear to learn this pseudoscience disgrace to evidence-based medicine. At the very least, the coagulation cascade should be removed from Step 1 until after I take the exam."

–Stuart Christmas Hageman, M2.

"I have always been a fan of primary hemostasis. Platelets are noncontroversial, they work hard and do not get the proper credit they deserve." –*Venus Stacis, M3*.

Silas Helbig and Steven Latta are both second-year medical students at the FIU Herbert Wertheim College of Medicine.

#### H&P

Tucker Brady, DO

#### HPI:

This is a 26-year-old male who presents with the chief complaint of incompetence. He states that for the past 12 months he has had no idea what he is doing. He states this seems to get worse every time he starts a new rotation and he has not found anything that provides relief. He states he has never experienced anything quite like this before as he has always been successful in school and sports. He describes the quality of his brain as dull and inept. He points right between his eyes when asked about the location. He rates the severity as a 10/10 at its worst and maybe 8/10 on a good day. He does report some nausea at the thought of having to present at academics but no vomiting, abdominal pain, or diarrhea. He reports occasional palpitations when involved in the care of a rather sick patient, but no chest pain, shortness of breath, or near-syncope. He also describes some paranoia and is convinced that the nursing staff thinks he is an idiot.

Past Medical History: Swears he attended medical school but cannot seem to account for anything learned during that time.

Past Surgical History: General surgery rotation as MS-3 but did not care for it.

#### Medications:

- -Balvenie Doublewood, 4oz, 1-2 glasses PO q7 days prn pain (recently increased)
- -Naps, daily, prn fatigue (patient not currently taking)

Allergies/Adverse Reactions: Being called upon in front of a large audience causes facial flushing.

*Social History:* Yes, used to go out frequently but states this has sharply declined since the start of residency.

Family History: Mother, Father, Sister—all living and intelligent

#### Physical Exam:

VŠ: BP 136/78, HR 99, RR not actually counted but maybe 16, O2 100% RA, T 99.9

Gen: Pale, appears fatigued, and in acute stress

HEENT: Pupils dilated, reactive, eyes darting around the room looking for the nearest exit

Chest: Small, poorly developed pectoral muscles, but nontender to palpation

Heart: Borderline tachycardic, murmurs of self-doubt, radial pulses probably not palpated

Lungs: No wheezes, crackles, or rales, but slight whimpering heard on exhalation

Abdomen: Thin, bowel sounds growling, ticklish but nontender Skin: Sunburnt at baseline, but warm, dry, intact

MSK: Full, painless ROM, hypotrophic biceps bilaterally Neuro: A&O to person and place but unsure what day it is anymore

Psych: Remotely resembles a sad panda

#### Labs/Imaging:

Glucose: 150 (though patient admits to recently eating an entire bag of Skittles)

CT head, non-contrast:

IMPRESSION: Wavy-appearing structures which resemble sulci and gyri potentially indicating the presence of a cerebrum, though this may represent artifact. Recommend clinical correlation.

#### Assessment/Plan:

This is a 26-year-old male presenting with chief complaint of incompetence which, despite his concerns, is gradually improving. Given the fact that residency exists to impart clinical competence, would recommend that he continue with his training under the supervision of his incredible staff and co-residents for the next three years to ensure the current upward trajectory continues. For his obvious lack of self-care, would certainly recommend more frequent meals as well as regular exercise and better sleep habits. For stress, would ensure regular communication with loved ones and friends to prevent feelings of isolation that may arise. The patient's advisors were consulted for an informal meeting involving beer and good food (appreciate their ongoing assistance with this case) and assured him that though life is challenging now, it does get better in time. All findings as well as the plan were relayed to the patient who indicates understanding and agreement with this course of action. Patient is hemodynamically stable and suitable for discharge.

Perry Pott, D.O.

Write for the Bunion: It's not scary *The Bunion* is a place for satirical medical news and humor related to experiences with which medical students, faculty, and clinicians are all familiar. Such experiences can involve the FSU College of Medicine, the medical school experience, or healthcare in general. Content is not intended to offend or humiliate anyone. All names are factitious and any resemblance to actual people would be merely coincidental. Submit to *The Bunion* through the HEAL submission site: https://journals.flvc.org/heal

Dr. Brady is PGY-3 Emergency Medicine resident at Naval Medical Center San Diego. He graduated from Des Moines University College of Osteopathic Medicine in 2019 and has maintained his love of creative writing throughout his medical training. The views reflected in this piece represent his own and do not necessarily reflect the official views of the U.S. government, the Department of Defense, or the U.S. Navy and do not imply endorsement thereof.





## On the Back Cover

#### FINDING BEAUTY

Anna Kenney

Anna Kenney is a second-year medical student at FIU Herbert Wertheim College of Medicine. She makes great efforts to find time for her art despite the demands of medical school, and she hopes to incorporate these skills into her future practice as a psychiatrist.

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