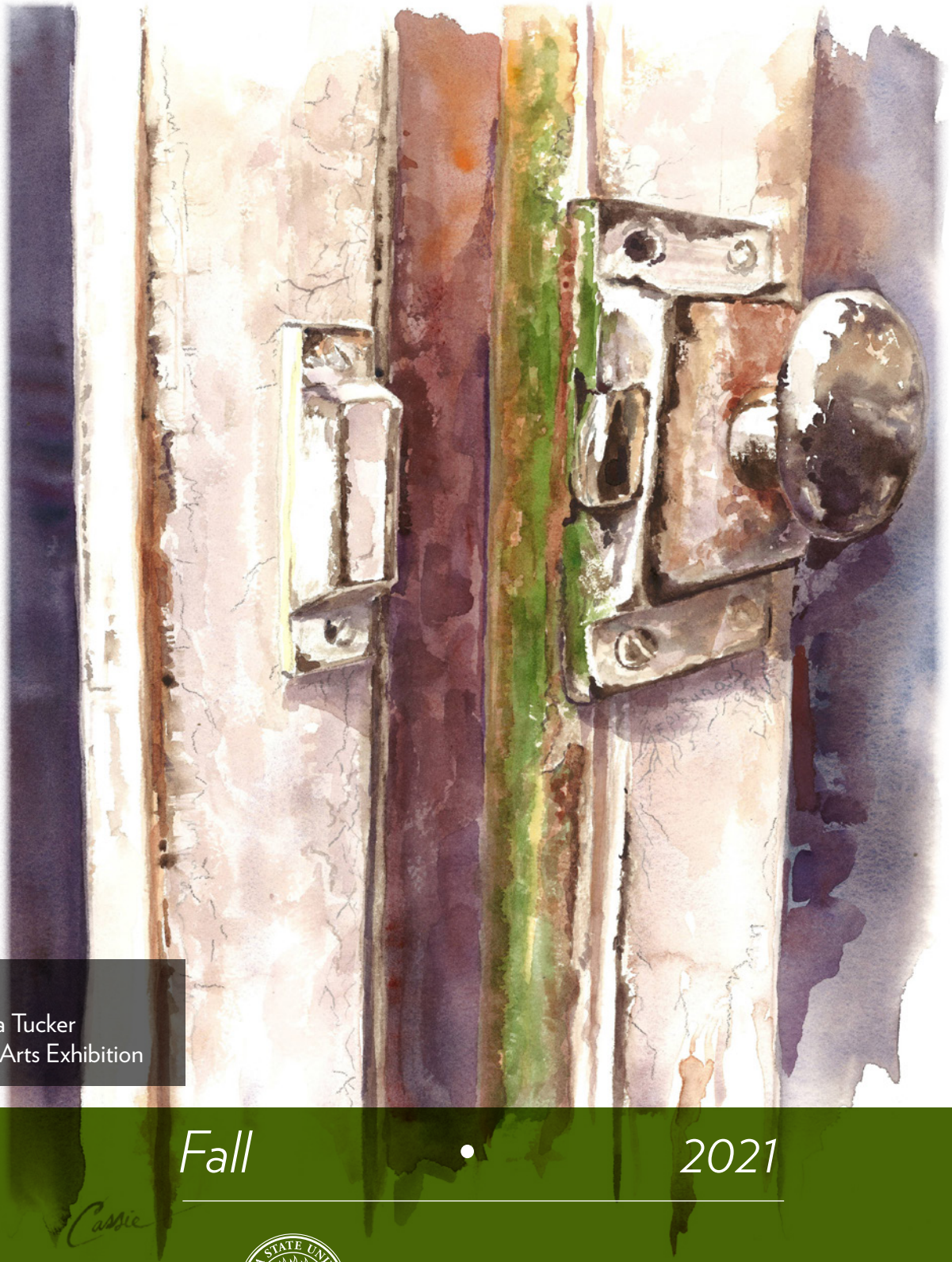
HEAL

Humanism Evolving through Arts and Literature



ESCAPE
Cassandra Tucker
Gadsden Arts Exhibition

Fall • 2021

FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

PROSE

POETRY

ARTWORK

time

Anabelle Rosenthal, Class of 2024

morning coffee, strong and dark
birds singing, the warmth of the sun
a cat dosing peacefully, lulled by sounds of spring

I try and grasp it all, before its gone
"live in the moment or you will regret it" I remind myself
and yet I find I cannot bottle time

I cannot stop its flow or save these moments no matter how I try
it rushes on with no regard for me or mine
always rushing, rushing by

soon I wonder, what will be left of mine?

Lead Editors
Sean Gabany
Raymond VerVoort

Editorial Team
Cheyenne Andrew
Rachel Cathey
Rida Darji
Sarah Hegleh
Hanna Lateef
JT Parker
Anabelle Rosenthal
Shwetha Shetty
Kirstie Walters

Faculty Clinician Editor
Suzanne Harrison, PhD

Faculty Managing Editor
Tana Jean Welch, PhD

Layout
Instructional Design & Media Prodution

Support Provided by
The Jules B. Chapman and Annie Lou Chapman Private Foundation

I Bleed Water

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

tears come now as
flash floods in the dark
drown me like cars
found three days later
in state parks
in sewers
where rumors of my death
are readily confirmed
I'm vehicles and crashes
printed pages and questions
why didn't somebody
see something, say something
about that dimming spark

I always feel amazed
that any blood remains
behind the furling scars
and petrified edges
of wounds I force to close
that nothing works to hold
except saying
no, all over again
I spend
such time repeating it, feeling it
squeeze out my joy
to pull together skin

20 years, or was it 10
I mourn the best of me
all over again and again
and I bleed water
I bleed steam
the rivers in between us
just falling out of me
some evidence of where I'm wrong
or what else could it mean
I don't need your love, I said
I do not need
your love
to wash me clean

For those of us who have survived abuse, seeing widespread coverage of its terrible consequences in national media can be both affirming and chilling. Our moments of intense despair when those images and words become especially heavy also do not occur in a vacuum, but rather within far more complex contexts of grief and healing. Something as common and usual as menstruating can trigger shattering memories of physical and psychological injury alike. Even many years of intentional work later, some wounds still feel as if they never quite close. And the feeling of being dirty, of needing to fix the broken things inside of us, never quite washes away no matter how many tears or how much blood we shed. I found myself thinking about all of this recently, reflecting on all the red flags people missed with me. I felt instantly overwhelmed by sorrow about how I ignored many of those same warning signs with myself because I had already internalized the message that I deserved to be hurt. I remembered seeing stories in the news about people driving into floodwaters and having their cars sucked into sewers, found days later in faraway places. We often do not learn people's stories until they have already drowned, whether literally or figuratively. Years later, I still find myself wringing out floodwater from my life. I am fortunate to do this with the love and support of my wife, a fellow survivor who lights my path forward every single day. Although the work continues, I am learning that I will never need another person's validation to justify my own existence or worth.

—Xan Nowakowski

THE BEAUTY OF AN ISOLATED ISLAND IN ALASKA'S INSIDE PASSAGE ON A FOGGY DAY
Debbie McCullis

WE TALKED ABOUT THE TREES IN TALLAHASSEE

Rachael Sabra, Class of 2022

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

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

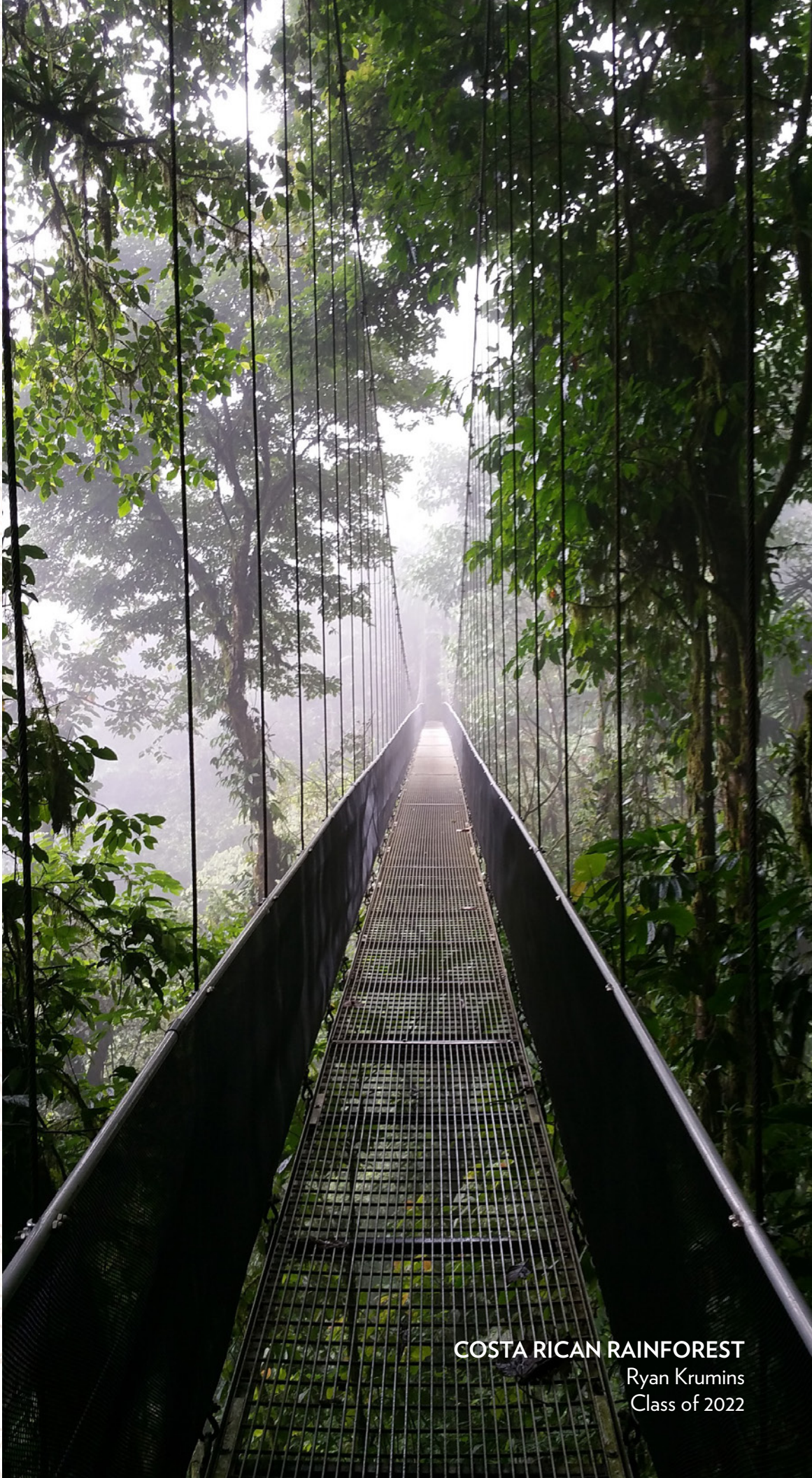
And in this field, you have to fight for your patient's health more than I could have ever imagined. You have to fight for your patient against for-profit insurance companies and against the pervasive misinformation within our society. Some days you even have to fight with your patients, with your stubbornness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

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

I've thought about that patient more then any other encounter in my entire life. I wonder how many others share this story. The justice system had changed a punishment designed to reform a wayward citizen into a death sentence. The right diagnosis at the right time held hostage by an inflexible system with a deeply engrained disregard for human life. It had been a non-violent offense.

The abuse of a substance that should have triggered a response of help or drug rehab instead of criminal punishment. We let this man down. We carried out capital punishment.

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



COSTA RICAN RAINFOREST
Ryan Krumins
Class of 2022

FLIGHT DREAMS #5
Mary Jane Lord
Gadsden Arts Exhibition

LIFE IN THE MARGINS

Miguel Cruz

At the time, I was merely a robot that converted caffeine and ibuprofen to clinical research. That day, 72 hours into a stress migraine, I needed a triple dose.
It was a late Wednesday, and this was our 7th suicidal patient for an intensive clinical trial. Over the course of two weeks, the patient would receive 8 doses of hallucinogenic antidepressant. Most intensive were the first four days, where three dosings would take place, along with a mind-numbing number of physical and mental assessments. In order to cram every task into a working day, I was waking up at 5am and leaving as late as 11pm.

The ketamine trial was exhausting, but it was a rush knowing that I was working on the same drug that piqued my fascination in neuropsychiatry some 10 years ago. I remember hearing about ketamine in high school—that kooky scientists were using some sort of magic hallucinogenic horse tranquilizer, and it was curing treatment-resistant depression in minutes.

From the news stories, I could tell people were skeptical, scared even. As a hallucinogenic drug of potential abuse, ketamine subverted public values of what a promising drug ought to be. It also flew in the face of how we understood antidepressant neurotransmission.

Even as a young teen, I felt a kinship with the drug. We were both weirdos. At the time I first heard of ketamine, I was an angry 16 year-old skateboarding punk, complete with inked skin and a green mohawk. Ketamine was seen with similar legitimacy. But here we are, a decade later, both working at Johns Hopkins. It felt right.

However, my devotion to ketamine research was taking a toll, made ever too apparent by this umpteenth late day. In doing this consult, I had cancelled yet another dinner with my doting and ever-too-patient fiancé. We cherished each other so much, but the thrill of research put blinders on me, and soon I was putting work first, always. There were times we argued about it—how the person she met was more laid back, less concerned about his career, and more concerned with living. But I had never found a niche before, never been one to excel. As I became less and less a miscreant and more a legitimate scholar, I found the prospect of discovery and achievement too intoxicating. So here I was, taking a patient history at 6pm.

"Ms. Stanley, I'm part of the research team and I just need to ask you a couple questions."

She was curled up in the fetal position, a wasting frame wrapped in a hospital blanket, facing the wall, eyes closed.

"Shoot," she said.

"So what's got you in here today? I heard they brought you up from the emergency room."

No answer. Oftentimes, it's better to wait. The suicidally depressed can exhibit "psychomotor slowing." After a bit, I realized she was just ignoring me.

"Strike one," Ms. Stanley said. "Next question."

"Sure thing, we can get back to that when you're feeling better. How are you feeling right now?"

"I'm hungry."

"Well, we can get you something to eat."

I thought that'd pique her interest. Sometimes it's best to come with a peace offering. Those who are suicidal, at the end of their rope, aren't usually in a friendly or conversational mood. Either way, the draw of bedside hospital food proved inadequate, so I continued.

"Ok, since we have a bit of time, how about I just brief you on the study. We'll need you to sign something at the end of our talk. I'm going to try to summarize everything you need to know, and then we'll leave this consent form with you as well."

"Fine. Go."

I went through the form and kept things as condensed as possible. In the end, I asked her to sign. Silence. Perhaps she was asleep. But no.

"Strike two."

At this point, I'd given up. She was tired. She needed time. So I cracked a horrible joke instead.

"Aw man, this feels like little league all over again."

Then I heard the tiniest suppressed chuckle. Still in the fetal position, she gives her head a quarter turn in my direction, more towards the ceiling than me.

"Strike three, you're out." There was now the slightest inflection in her voice. Bingo.

Just the smallest bit of banter goes a long way. She finally turned to face me.

"Well ref, I'll have to contest that ruling." She didn't respond, but I had an opening, so I pushed forward with the medical history. "Since you've been so mean to me, I think the least you can do is work with me on this consent form."

Silence again, but this time, I knew she was attentive. I didn't need to repeat the summary. She'd been listening.

"Is this going to get me better?"

"We can't promise anything, but I'm working on this drug because I believe in it."

"Well, I don't believe in you, but I'll sign anyway" she joked.

"You sound just like my father."

She chuckled again. While suicidal depression can wear people down to the bone, it's interesting to see what signs of life persist. Humor, I learned, was always welcome, and often reciprocated. Another was love—love for pets, romantic partners, family, friends, often in that order of priority. Most peculiar of all was an appreciation for music. One of our most despondent patients in the study, who needed every word coaxed out of him, could still ardently request we play Drake's new album during his dosing visits.

By then 6pm was turning to 7. I was still in the unit, which was always slightly too warm for business casual, killing time that I didn't have. I thought I'd try to get her history again.

"So what's gotten you in here today?"

"The usual."

"It says in here you tried to jump in front of traffic."

"Yeah, the usual."

"What made you want to do that?" Then I strategically paused. It's an art concealing a barrage of clinical questions into a seeming conversation. The length of pause between questions is the difference between innocent curiosity and an interrogation, so I never paused for too long. "What have you been feeling up to that point?"

"Just… bad."

"Have you been taking your meds? It looks like you're been prescribed everything under the sun."

"The pharmacy's too far away. I crashed my car so I just stopped going. Plus, what's the point? They don't make me feel better."

"But they will! I know you've probably heard this a million times but you gotta stick with it. These meds take like… 4 to 6 weeks."

"Meh."

That indicated to me a potential dead end. Awkward silences are bad for healthy people, but for the anxious, it could be sickening. So in doubt, fill the silence with a pertinent compliment.

"So you've been handling all this life stuff without your meds. That's pretty gnarly."

"Gnarly? Are you a surfer or a doctor?"

"I'm from California actually. I get that a lot."

Another method for establishing rapport is sharing personal details, and my accent, I learned, piques the curiosity of many a patient. The downside? My boss once half-joked that I liked to get high on the job. One doesn't typically expect my sort of persona in a white coat.

But the ice was finally broken, and with that, I could finally get her history.

It turned out she was out of a job and her brother just contracted HIV. What's more, her long-term relationship had gotten emotionally abusive, which was made ever more complicated by her new financial dependence on the abuser. She spent her days hunting for jobs, trying to coordinate care for her brother, all the while finding every excuse to avoid the

house. The situation had been dragging on for two years.

Since working on the suicide study, I'd learned not just what people still loved, but also what is hated. Family tops this list as well. Finances are the other killer. It's just too painful knowing one can't provide for themselves and those who they care about; it reflects not just a lack of efficacy, but in our society, a lack of worth.

I learned she was a writer. While she had not completed high school, she was well read and whip-smart. I felt like an utter troglodyte talking to her.

"You ever read Wallace?" she asked.

"Like the British dude with the dog? Wallace and Grommet?"

"No, David Foster Wallace. It's like what he said about 9/11. The people standing at the window didn't want to jump, but what's inside was gonna kill them. So they jumped anyway. I want to live, but I have no way out. I'm always working but I'm not getting paid. I'm not afraid to jump anymore."

They were sad words, but ones spoken with levity, of someone who had long surrendered—who'd suffered for so long that pain was just a plain fact, like the weather. This too, is common among the extremely depressed.

"My entire life is just doing, I'm not living. Life can't be lived on the margins."

That line hit me like a brick. Working on the floor at 7pm, a days worth of unsightly perspiration collecting on the underarms of my borrowed white coat, her passing comment brought my childish myopia, my rat race mentality, my unnecessary dedication to work that could very well be done tomorrow, all to bear.

There's nothing like a psychiatric consult to reveal life's wisdoms, the accumulation of which is greatly accelerated through relentless psychological suffering. Though every patient is different, it seems that those who are close to death—be it the aged, the terminally ill, or the suicidal—achieve a sort of matter-of-factness that peels away pretenses about themselves and others.

As I finished collecting her history, I saw the conversation was fatiguing her. Severe depression is an odd beast. It's not just a mood thing. Sometimes the fog of depression makes it hard to keep track of a conversation. Social anxiety is also very common.

"Ms. Stanley, thank you for your time. I'll let the doctors and nurses know that we'll begin our first dosing tomorrow."

No response. I think this time she was actually asleep.

Riding home, her words rung through my head as I examined my own life. I loved my job. Connecting with patients is a distinct privilege. I'm endlessly fascinated with neuropsychiatry, a study of what physics govern the mind. But I looked at what our patients love and what they hate, and how my life compared: when people are close to death, they care about loved ones, and here I was, denying myself to people who loved me the most.

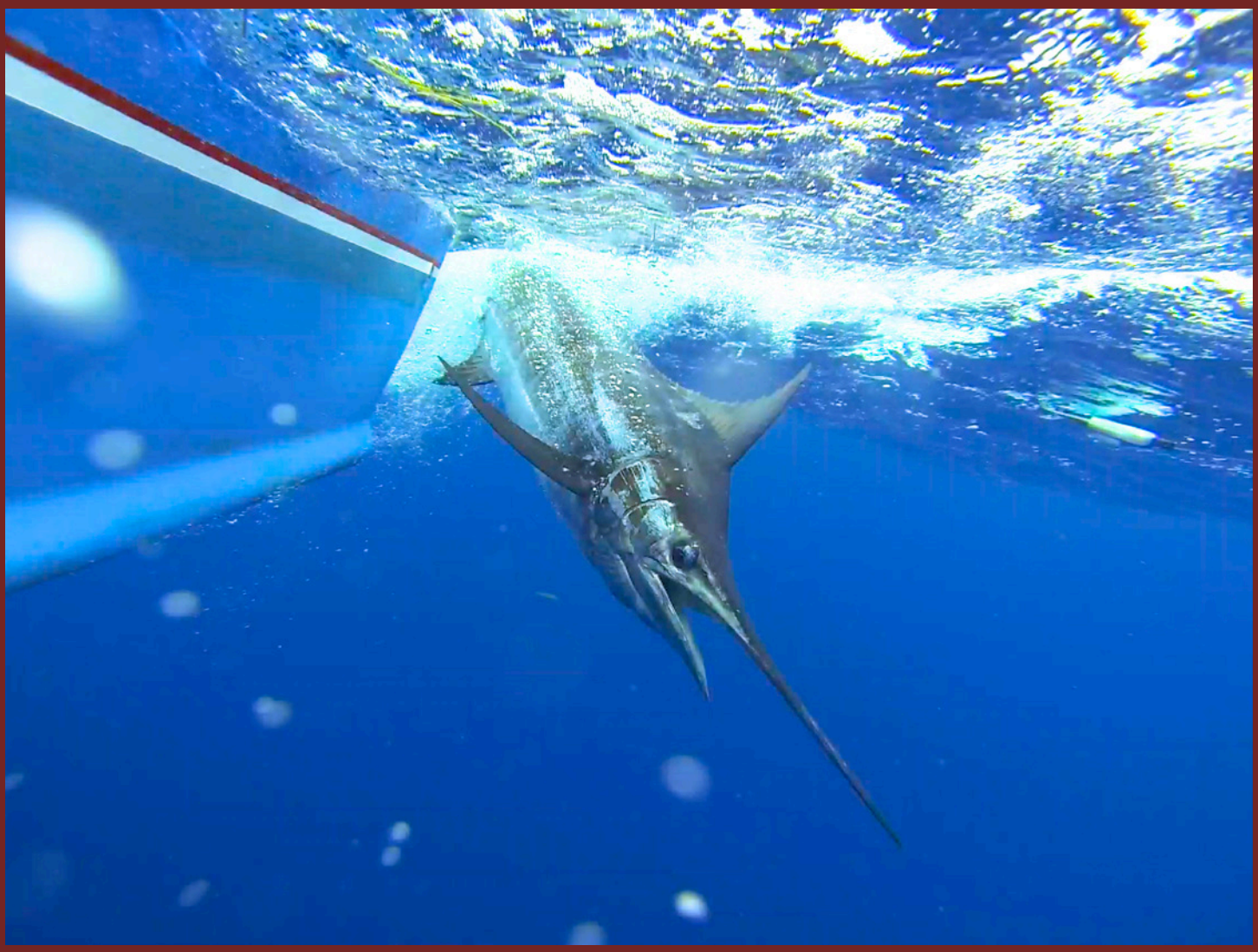
In reflection, I saw myself treading down the same grooves as some of my patients. Life was miserable, so I developed maladaptations. My fix was workaholism, and I relied on the rush of achievement to carry on. In the process of chasing a high, I began neglecting my core sources of meaning—family, friends, pets, hobbies—the only forces strong enough to buoy me through life's storms.

I then thought to myself, if I shared a room with Ms. Stanley, what would hold me back from jumping to my death?

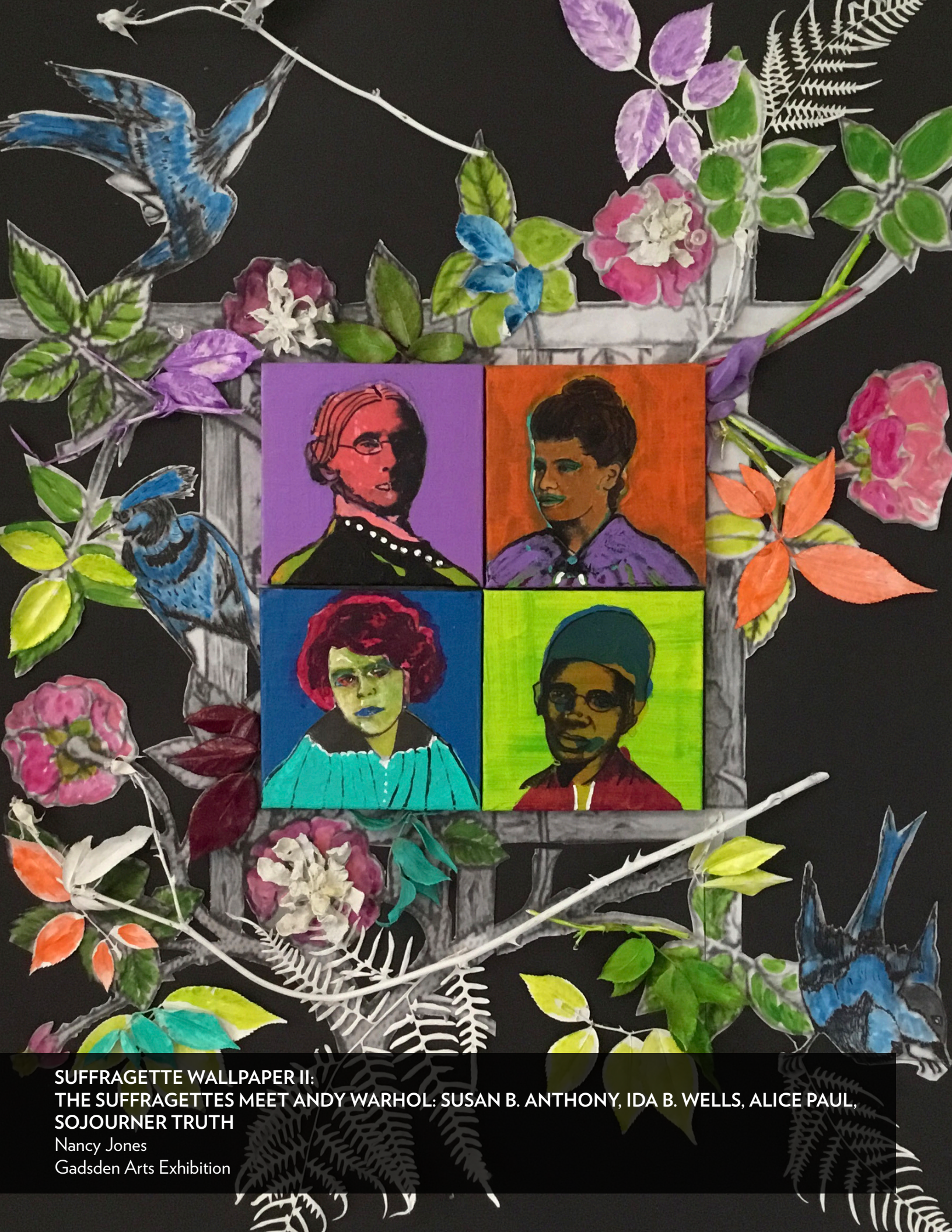
Indeed, working in medicine was an acceptable salve for the sting of cosmic nihilism, but through Ms. Stanley's passing comment—that life could not be lived on the margins—the most powerful anchors to life became clear. Duty was not among them.

As I headed home, I craved more than ever to see my fiancé's face. I wanted to hold her, smell her hair, and tell her how sorry I was. I wanted nothing more than to crack open a bottle of wine, turn on our favorite music, and order from the same Ethiopian restaurant we had our first dates in. I knew then, should I pass the next day, I would have no regrets.

Miguel Cruz is a retired neuroimmunologist who conducted basic and clinical research of psychedelics at Johns Hopkins. He is the author of Death of a Child, *an upcoming satirical nonfiction book about a dysfunctional academic using his own suicidality and drug abuse to generate successful psychedelic treatments.*



BLUE MARLIN
Ryan Krumins
Class of 2022



SUFFRAGETTE WALLPAPER II:
THE SUFFRAGETTES MEET ANDY WARHOL: SUSAN B. ANTHONY, IDA B. WELLS, ALICE PAUL, SOJOURNER TRUTH
Nancy Jones
Gadsden Arts Exhibition

Bitter Wine

Stacey Maslow, MD

Smiling,
she approaches.
We hug.
Billowing ruffles of her purple sweater tickle me.
Purple—
her daughter's favorite color.

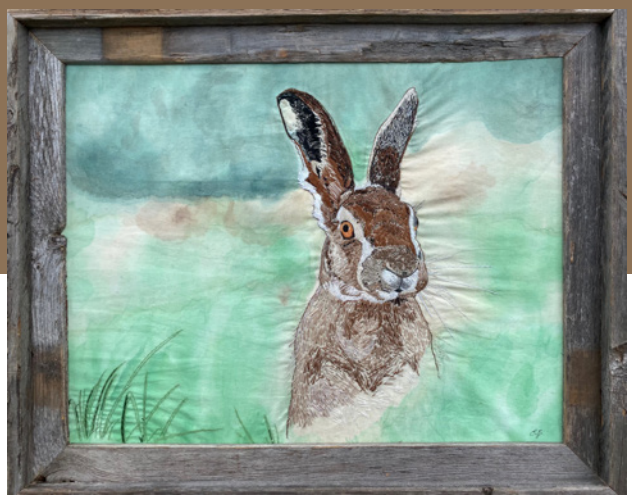
Stepping forward
blindly,
with eyes open,
I see—
Her.

She lies
serene,
a vestigial raison
radiant in her coffin.

Peering eyes incise
her indigo-clad flesh.
Blackness encases me.
A long pause knifes my core.

Propelled forward
by the weight of the crowd
heavy on my back,
leaden legs soldier me onward.

Dr. Maslow is a practicing pediatrician who advocates for education and improvement of the lives of others through work with immigrant health and medical philanthropy. She is also a photographer, writer, interior designer, and athlete.



HAZEL
Erin Bowen
Gadsden Arts Exhibition

COVID CASCADE KILLED MY FATHER

Helen Meldrum, EdD
Bentley University

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

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

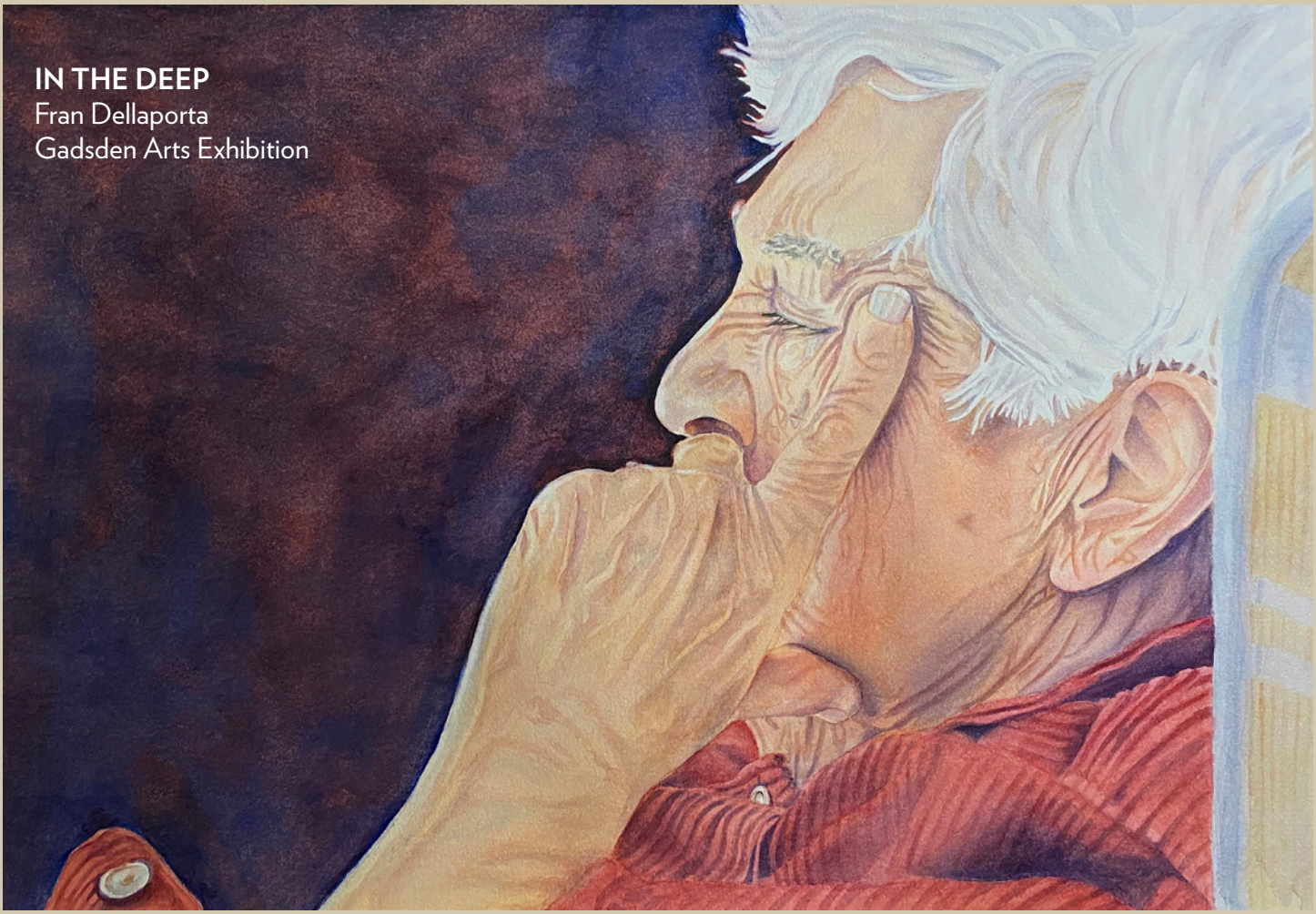
All this changed as COVID-19 surged in his county. The circumstances of the outbreak in his facility are extraordinary. In contrast to most nursing home plagues reported in the media, with common rates of about 40 infected patients to 4 infected staff, my father's building had about 20 infected staff and only 4 COVID-19 positive patients. Since the facility locked down in early March, with no access by anyone except residents and staff, it seems clear that the patients acquired the virus directly from their caregivers. The facility—like most in the US—had no ability to acquire N95 masks with superior particulate filtering. And yet, as one of my loved ones trained as an infectious disease doctor stated before everyone caught on: "This virus spreads through the air like Tuberculosis."

The effect of the outbreak was to isolate my father from his usual care. With elective surgeries canceled, my father's large, free-standing unit was no longer financially viable. His long-term caretakers were reassigned, and his nearby nursing desk shut down, replaced by a new "COVID Unit" with a Plexiglass-type barrier to direct airflow away from his room, leaving him alone at the end of a now irrelevant corridor,

without even so much as nearby foot traffic by his known caregivers. With the word of the outbreak in the local media, the facility reported an inability to recruit and retain adequate temporary staff.

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

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



IN THE DEEP
Fran Dellaporta
Gadsden Arts Exhibition

on the rehab unit have really been neglected." We agreed that rather than assume the risks of transporting him to the hospital late at night, in the morning a mobile imaging machine would be brought in to assess him.

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

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

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

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

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

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

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

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

Dr. Meldrum is an associate professor of psychology and director of the program in health and industry at Bentley University in Waltham, Massachusetts. She has a particular strength in teaching "teaching skills," having facilitated many train-the-trainer programs in health communication in the U.S., Canada, Europe and Israel.

WHOOPING CRANE DANCE
Kathleen Wilcox
Gadsden Arts Exhibition