

# H E A L

Humanism Evolving through Arts and Literature



BLACK BEAUTY  
Ramiz Kseri, MD  
Department of Clinical Sciences

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20  
*Ramiz Kseri*

Winter

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2021



FLORIDA STATE UNIVERSITY  
COLLEGE OF MEDICINE

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# A Shoulder to Cry On

Tabor Flickinger, MD, MPH

I rest my salty zygomatic arch

Within the welcome hollow where

Your pectoralis and your deltoid touch

While, deep to me, your polarizing plexus

Sparks down myelin sheaths, each flare

Excites its motion: one extends, one flexes.

Thus, your arms embrace me. Thus, you knead

My tense trapezius and from

Your fingers all distress of flesh recedes.

Our vagal nerves seep comfort, slow our hearts.

They beat together: we become

More than the sum of these, our mortal parts.

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

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### Layout

Instructional Design &  
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### Support Provided by

The Jules B. Chapman

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HEAL is a place for medical students to share their growth and development, for faculty and staff to impart their knowledge gained from experience, and for members of the community to express how health and healing have impacted their lives.

We hope this work increases your appreciation for the art of medicine.

# DAYS, WEEKS, MONTHS

Brooke Lajeunesse, Class of 2021

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

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

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

So, once again, I entered the “party.” My attending looked at me and said, “Get on that chest.” I grabbed some gloves and took over compressions. “Push hard and fast,” I could hear the American Heart Association instructor in my head. The patient was purple from the chest up, his eyes open with the 1,000-yard stare. I wondered if he could see anything, think anything. He was diaphoretic and cold. I thought back to all the times we coded someone in the

ambulance and they looked like this, the whispers of the paramedics saying “he’s super dead” or “no way this guy has any brain function left.” I couldn’t help but think the same thing. He had already been down for 20 minutes; the outcome couldn’t be good. I pushed hard and fast, taking turns with a nurse, both of us fatigued. My attending obtained femoral artery access in anticipation for cardiac catheterization. As he held pressure on the femoral artery, he also assessed for a pulse.

I continued compressions, feeling the sternum crack under the weight of my body. That was a first for me and definitely not my favorite feeling in the world. Suddenly, my attending yelled, “Hold compressions!” Seconds, which felt like minutes, went by before he said, “We got a pulse!” I couldn’t believe it; our team had gotten a pulse! In the following minutes, we worked quickly and carefully to prepare the patient for transportation to the cath lab. The elevator was being held and my attending and I rode the gurney through its doors alongside our patient. The catheterization procedure was touch and go, but in the end, he made it through. An Impella device was placed to take some strain off his weak heart, and he was moved to the ICU for further care. My attending and I returned to business as usual and went to the ICU later that afternoon to check on our patient. When we arrived on the ICU floor, we were greeted by our patient’s nursing team exclaiming, “Your patient is awake and responding to commands!” I could have cried. This was not my first experience being part of a code. It wasn’t even the first time my code team had gotten a return of spontaneous circulation. But this was the first time I had ever seen my patient wake up fully oriented. Even my attending was amazed. Then it all hit me. I was a part of that; I helped bring this guy back to life. How often will I get to see that?

The most rewarding part was that this was my patient and



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

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



THE WAR ON COVID  
Maheen Islam  
Class of 2021



# The Used Heart Club

Wendy Hind, PhD, JD

Can I listen to your heart?

The middle-aged woman places her head on my chest.  
This should be weird,  
but it's not.

It's overwhelming though,  
and we both begin to gently cry.

I am the newest member of a very exclusive club.  
With this club there are risks and strict protocols.  
With this club there is joy, guilt, and fear of rejection.

Since receiving my new heart,  
I feel different.  
I don't want to tell anyone what I'm thinking and feeling,  
but I am a different version of myself.

If you're a member of this club,  
you understand.

The woman's breath grows warm on my chest.  
Her head is getting heavy.  
My shirt is getting wet.

Her son's heart beats in me now.  
She remembers listening to it,  
when he was a boy.

Her worst nightmare is my greatest gift.  
I promise I will take care of his heart.

She can always come and listen to our heart.

*Dr. Hind is a former professor and university vice president. She became involved in narrative medicine after her son was born with Hypoplastic Left Heart Syndrome. She has published poems and essays in several journals such as The Healing Muse, Blood and Thunder, and Hektoen International.*



**AFRICAN FEATHERED FRIEND**  
Randall Fisher, DPM

*Dr. Fisher retired from a career in medicine and surgery of the foot in late 2017. He discovered his passion for travel while still in his teens, and thus far has visited approximately 65 countries, always with camera in hand. His favorite photography subjects include wildlife, landscapes, and, of course, people.*

# An Audience

Shelby Hartwell, Class of 2021

There were six providers stuffed into the room; the nurse in training and her seasoned counterpart, the student stenographer and her teacher, and myself with my preceptor. Our patient sat on the edge of the table crammed into the corner with this gaggle of women clad in scrubs standing around her. We were her audience and she did not know that she was to be on stage for her abortion that day.

We conversed in English as we fussed over the phone to get the interpreter line for Haitian Creole. Our patient even more nervous now, realizing no one in her audience could understand her. A woman on the other end of the phone finally answered and introduced herself.

“Alo mwen se tradiktè ou.”

“Hello, I am the doctor, please let our patient know.”

The doctor proceeded to recite the monologue she performed for each patient. Much of which consisted of verbiage dictated by the state to be discussed with patients procuring abortions. Our patient nodding along as her one invisible audience member translated.

“Any questions?” the doctor finally asked.

“Nenpòt kesyon?” spoke the voice through the phone. Nothing came out of our patient’s mouth, but her eyes darted around the room to each of her audience members. She shook her head no.

The doctor hung up the translator line and everyone began to take their places. I stood in the corner of the room in silence, like a good medical student, my own gloves and face-shield in hand, waiting to be called forward. The speculum and dilators clanked against one another as the doctor set up the instrument tray, then she looked up at all of us with apprehension.

“Actually, you both,” she motioned to the ultrasound tech student and myself, “would you mind stepping out? I didn’t have a chance to ask her permission for a student to be present.” We of course both stepped out of the room.

Throughout my education, I have tagged along on many clinical experiences. From the open laparotomy to the shave biopsy, I had always assumed that my preceptor had gotten appropriate consent from the patient that I would be present or assisting. Although, in hindsight, I can recall times when I was barely introduced and still expected to participate. I have even heard of preceptors at other institutions encouraging students to practice invasive pelvic exams on sedated patients without explicit consent; luckily, I have never faced this ethical dilemma. In these instances, my education as a medical student has been placed as the priority, with preceptors insisting that I get to see ‘interesting’ cases and patient stories.

My preceptor that day at the abortion clinic could have allowed me to stay and participate. No one would have reported her; there would have been no repercussions. Our patient was in no position to defend herself. Any gynecological care places patients in a vulnerable position, both physically, with positioning in ‘stirrups,’ and mentally, with the emotional relationship we have with our intimate body parts. But this patient, unable to communicate easily with her providers, was doubly vulnerable. My preceptor put the patient’s respect and privacy first above all else.

It is easy for us as healthcare providers to become accustomed to being wanted guests in our patients’ lives. And as medical students, we become accustomed to being welcome spectators to our patients’ problems. Our patient’s stories and experiences are a privilege to be a part of, not a right. As I stood on the other side of the door, I knew that my absence was benefiting our patient more than my presence ever would have.



# Sunrise at Albert Einstein College of Medicine

Miguel Rodriguez

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

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

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

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

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

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

*Miguel Rodriguez is a graduating medical student at Albert Einstein College of Medicine who woke up to beautiful sunrises for 5 years. This poem encapsules the loss and growth, the re-birth and persistence, the small things that push us forward as we begin our medical journey.*



**ZANZIBAR SUNSET**  
Randall Fisher, DPM



An

# IMPOSSIBLE

## Decision

Isabel Cohen

My mom was diagnosed with stage IV brain cancer on an early-March day that promised nothing but a humid cold seeping through to the bones. It was the dreaded glioblastoma—the most aggressive beast of its kind. Although the outlook was bleak, she opted for the typical chain of treatment options designed to extend the life of a cancer patient. First was the surgery to remove the six-centimeter-wide tumor that had ballooned across both hemispheres of her frontal lobe. Six weeks later, she underwent her first radiation and chemotherapy treatments, completing one full round. But soon after, just as the oncologist was gearing up for a second round of more intense chemotherapy treatment, my three sisters and I put on the brakes.

Because here's the thing: my mom's cancer was incurable—she had no chance of remission. And as the cancer attacked her brain, her quality of life plummeted. The mass, located in an area of the brain responsible for executive functioning, personality, emotions, memory, problem solving, social interaction, and motor function, ate away at all of the above capabilities until my mom became a stranger who could no longer care for herself in any capacity, who lived in diapers, and who spent her days watching television and sleeping, unable to continue her work as a beloved school nurse or pursue her passion for gardening or care for her pets and children. She could no longer remember what she had done the day before or what she would do the next. She could no longer perceive her effect on others, or even care. She lost nearly all emotional ability, and, at times, could hardly recognize the people she loved the most.

The cancer destroyed my mom at the very core of what makes a person who they are, and yet, here was her oncologist, practically jumping for joy at the prospect of sending another cocktail of toxins, another army of laser beams, to halt the growth of the tumor. And we followed his lead. Because he was the doctor and he knew what was best. Right?

But behind the oncologist's back, we questioned the path—when we returned our mom to her bed in the middle of the night after she wandered off without pants, sitting on the neighbor's stoop reading his discarded newspaper. Or when she lost control of all movement in the left side of her body and fell with a sickening and bloody crack to the bathroom floor, her head busting wide open. Or when she could no longer walk and was forced to retire to a wheelchair, her muscles atrophying beneath our touch.

In a constant loop, we asked ourselves, “Is this what Mom would have wanted?” And, even if not, how could we live with ourselves if we stopped fighting for her?

Our mom left us clear medical directives before she got sick—she did not want any extreme measures taken to keep her alive. But these instructions referred to being kept alive artificially, on life support, with a machine acting as her heart and lungs. If it ever came to that, she didn't want us to think twice about flipping the switch. The instructions hadn't included a clause about brain tumors.



## ROLLING FARMLAND OF THE PALOUSE

Randall Fisher, DPM

“If she had known she would become like this, she would have begged us to kill her,” one of my sisters said during a discussion about what stopping treatments would mean. “She would be so mad at us if she knew we let her continue living like this.”

I could imagine my mom’s horror if she had been able to see the way her life would end. She would have been repulsed by her complete dependence on others, especially her children. I could picture her demanding we let her go, her finger wagging, her jaw tightening as she looked into each of our eyes. Don’t any of you dare let me live like that, she would say.

But that was before, and this was now. And the path wasn’t so clear cut, it wasn’t black or white, live or die. A sweet, childlike person had come to inhabit my mom’s body, a person who was still partly her. A person who still talked about where she would retire one day and about getting to go home to her brick house on the hill, which was now impossible because she needed 24/7 care in a full-time facility. This person asked us when she could go back to work and why her dogs no longer lived with her. And then this person would forget all the answers and ask them again.

My mom didn’t know she was sick, and she didn’t know the disease would one day kill her. But she wasn’t in any pain, and thus, it wasn’t easy to tell the oncologist we were no longer interested in curative treatments.

Whenever I thought about the possibility of discontinuing treatments, a tiny voice liked to creep in and ask, “But what if...?” What if this treatment allowed her to live another year and reversed the damage of the tumor? What if she could live with minimal symptoms because of this therapy? What if one of the new cancer studies is the key to curing her disease?

The “what-ifs” were never-ending, nor were they surprising. We live in a society that leads everyone

to believe they are the exception to the limitations of the body. Dying happens to other people, not to those who pursue the path of medicine. My dad is a colorectal surgeon and when I was little, I would tell my friends, “My dad saves lives,” the pride knocking around in my chest as I watched their shocked faces, in awe of my dad’s superpowers. When my mom got sick, I learned that there was another definition for what doctors did: they postponed death. Sometimes at all costs.

“

*When my mom got sick, I learned that there was another definition for what doctors did: they postponed death.*

This was the downside to medicine: a patient could never know if they would be one of the lucky ones, if the next treatment or therapy would prove successful in stalling the progression of their disease, in staving off death. And so, they continued down every possible route, arriving on their death bed with the chemicals still flowing through their blood vessels, the hope still obscuring the reality in front of their eyes. The doctors tell us all the ways we can fight, they give us medicine and then more medicine, they perform surgeries and procedures; there is always something they can do, whether or not it adds quality to life. But who tells us when to stop?

I watched my mom deteriorate in front of my eyes, knowing that more treatments could give me more time with her, even if she was no longer the mom I had always known, even if she could no longer remember my name, even if I had to bathe her and feed her and change her diapers and make sure her bills were paid. The oncologist dangled more time with my mom in front of my nose like a dog with a bone. He envisioned three more months, six, nine, a year. He wanted to reach beyond the limits of modern medicine. Meanwhile, all I wanted was to talk to my mom about the new job I had started or about the annoying thing one of my sisters had done or said. I wanted to ask her if my dog’s latest quirky behavior was normal. I wanted to hear her ramble on about her work drama while she periodically paused to yell at her own dogs to stop barking. I wanted her chaos and vivacity. I wanted just one more conversation.

She could live longer, the oncologist said. What he didn’t readily say was, “She could live longer, but only like this.”

But we didn’t blame him for his optimism, for his pushiness. For his profession was not an easy one—he was up against the

nastiest of tumors on a daily basis. He needed that potential extra year as much as we did. If he could postpone the day he had to look into each of our faces and tell us there was nothing more he could do, I couldn’t fault him for hanging on with all his strength.

For weeks, I sat at my mom’s bedside late into the night, watching her chest rise and fall with the heavy rhythm of her labored breathing, counting each breath, making sure her lungs continued pumping. I gazed at the patchy pattern of her radiation- and chemo-destroyed hair, which had left a prominent bald spot across the front half of her head and tufts of coarse gray fluff sticking out in all directions down the back and sides. The tight-knitted scar formed a swooping arch where the surgeon had cut her open and I liked to trace its gnarled surface from her forehead down to her ear with the tip of my finger. I traced the scar and counted her breaths until I couldn’t keep my eyes open any longer. And between each breath, I asked myself which was worse, being alive but unable to live a meaningful life, or death?

My sisters and I worried that turning our backs on treatment options was placing the decision of whether our mom lived or died into our hands. We worried that doing right by our mom meant clinging to every possibility of more time. Saying “no more” felt like pulling a trigger.

And we weren’t alone. Those closest to us had turned into our personal cheerleaders, urging us to “never give up” and to “hold onto hope.” Miracles happened every day, they said. Others told us stories about someone they had known or heard of who had beaten the odds, defied the statistics, cheated death. They were certain the same could happen for our mom if we “just kept fighting” and “stayed strong.” I always wondered why so many people equate death with giving up hope. Why does one have to cancel out the other? Humans are so curiously contradictory—we euthanize our beloved pets at the first sign of pain and suffering, yet we hold so tightly to our human loved one’s skeleton-thin hand as they drift in and out of this world and the next, begging with their tired eyes for it all to end.

There is a time to fight and treat and try to overcome cancer and there is a time to accept and rest and let go. We could have fought until the end, like so many people do, but we would have fought a losing battle. And at the end of the day, what were we even fighting anymore? Loss? Pain? Grief? Death? Here’s the secret many doctors don’t like to admit: Death always wins. We must not be afraid to let go.

After many sleepless nights, I realized that we were not choosing life or death in deciding whether our mom underwent more cancer treatments. Death was automatically chosen when she was diagnosed. We were simply removing



a barrier between her and death—a barrier that served no purpose other than to make her suffer through a simple, continued existence. This was not living. My sisters were in full agreement.

Within six weeks of telling the oncologist that enough was enough, I counted my mom's last breath. Her body finally slipped away to join all of the parts of her mind that she had already lost.

Stopping treatments for my mom was not giving up on her. It was giving her back some long-lost dignity. It was spending her final days fully present with her instead of focused on the vicious cycle of treatments and procedures, of false hopes. It was replacing the burden of more time with the beauty of what was still left to live together.

It was making the excruciating yet merciful decision to let her go.

*Isabel Cohen holds a Bachelor of Science degree in Psychology with a focus in Education. She currently works at an elementary school providing learning support for children with special educational needs while pursuing her passion for writing in her free time.*





# Scaling Pain

Suzanne Edison

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

But you, my son, are not  
grown, and the chart for kids is faces—  
at one end, a smile, and at its opposite,  
a tear-strewn frown  
which may describe your face

but not your knees, drum sticks  
throbbing as you hobble  
towards the school entrance,

late, most mornings, or the effort  
of unlatching your backpack,  
fingers swollen as pickles, or  
the way your heart wrenches and seals over  
when a classmate teases you for being slow.

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

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

*Suzanne Edison's recent chapbook, The Body Lives Its Undoing, was published in 2018. Her poetry can be found in: Michigan Quarterly Review, Seisma, JAMA, among other places. She lives in Seattle and teaches through Hugo House and in medical settings.*



**HAWAIIAN FLYING FISH**  
Randall Fisher, DPM

# PATIENTS BEFORE *Personal Sorrow*

Jennifer Caputo-Seidler

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

– Anton Chekhov, "Enemies"

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

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

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

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

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

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

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

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

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

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

Then the pager went off.

"MICU returning a page," I answered.

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

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

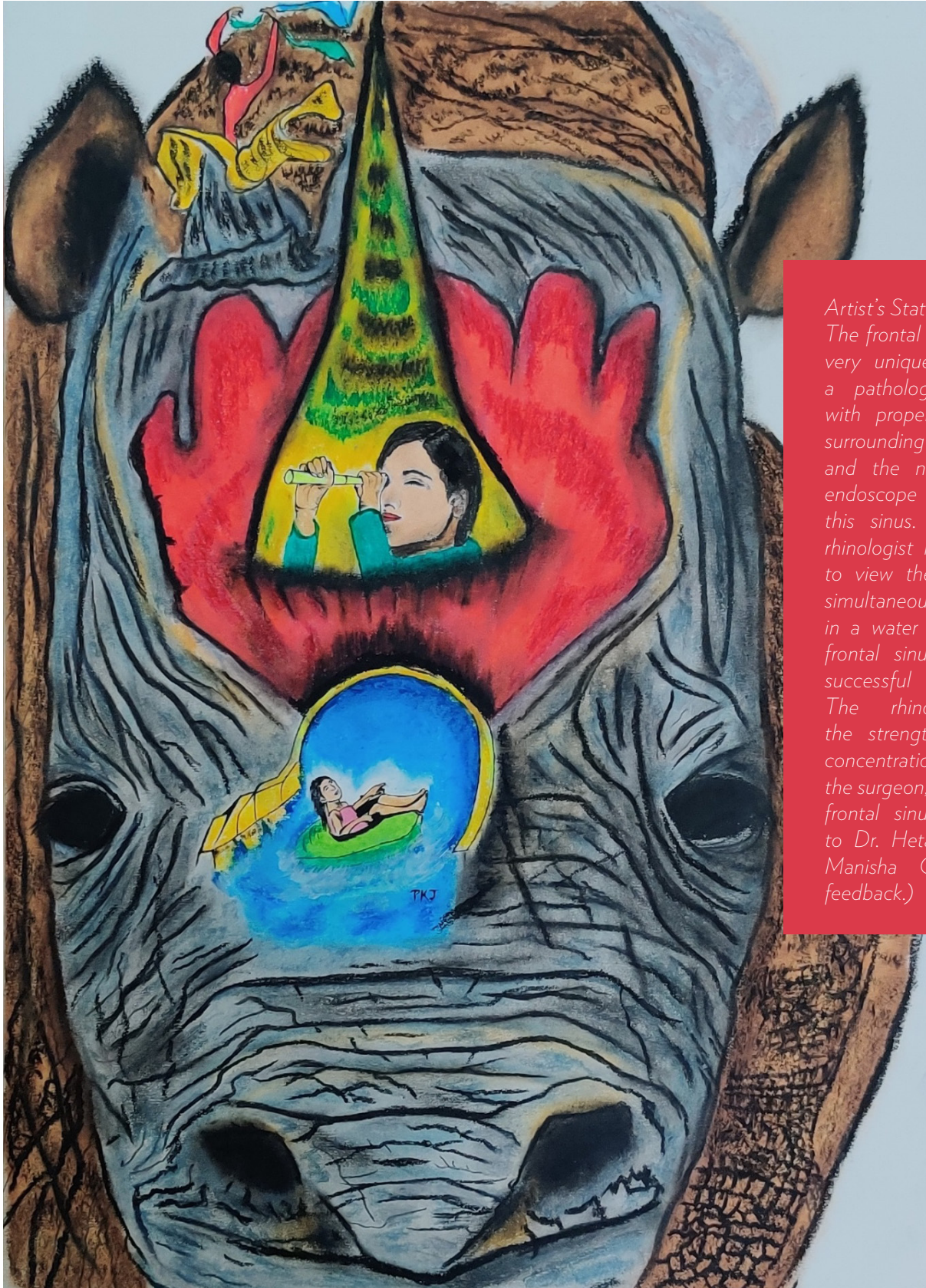
There was no time for my grief.

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



## RHINO FOR A RHINOLOGIST

Dr. Pankaj Goyal, MS, MBBS



### Artist's Statement:

The frontal sinus is situated in a very unique place. Sometimes a pathology can't be dealt with properly because of the surrounding delicate structure and the narrow opening. An endoscope is required to reach this sinus. In my painting, a rhinologist is using a telescope to view the frontal sinus and, simultaneously, a child is playing in a water park, which reflects frontal sinus drainage after a successful surgical clearance. The rhinoceros symbolizes the strength, hard work, and concentration required for both the surgeon, and the patient with frontal sinusitis. (With thanks to Dr. Hetal Marfatia and Dr. Manisha Chouhan for their feedback.)

Dr. Pankaj Goyal is an ENT surgeon at Seth G.S. Medical College and K.E.M. Hospital in Mumbai, India.





**THE MASK**  
Kiah McSwain  
Class of 2022