HEAL

Humanism Evolving through **Arts** and **Literature**

SPACE NEEDLE
Logan Malter
Class of 2023

Spring • 2022

FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

PROSE

POETRY

ARTWORK

THE 8TH 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.*

1st PLACE

EVOLVING

Laura Samander
Class of 2023

"Can you imagine? Hearing voices that no one else hears. Can you 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 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.

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. "Of course. I understand," I mustered.

My attending started with his first question to the patient.

"Where are you living right now?"

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? 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.

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 Mucor mycosis 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.

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.

FALCON 9
Logan Malter
Class of 2023

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.

FLOWERS IN HER HAIR
Maheen Islam, MD
Class of 2021

3rd PLACE

HEALING IN NATURE
Savannah Calleson
Class of 2025

A BRIDGE BETWEEN LIFE AND DEATH

Jeanah Kim, Class of 2022

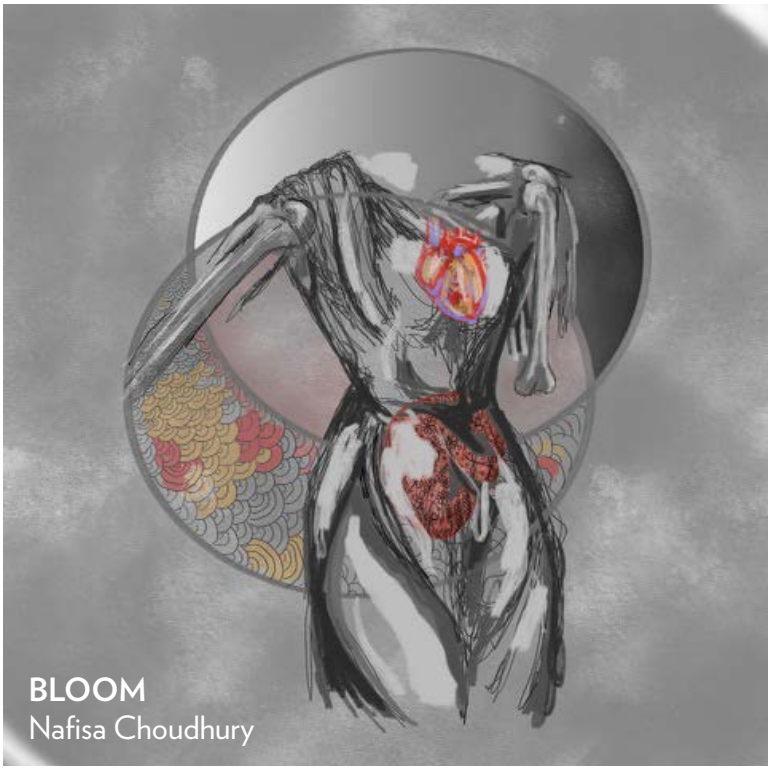
As medical students the impact we have on the patients we encounter is greatly impressed upon us. Yet, it is the patients we have the privilege of meeting who mold the way we treat each subsequent person. During my OBGYN rotation I experienced one of the greatest joys in medicine, bringing new life into 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.



BLOOM
Nafisa Choudhury

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.

Photo: Nafisa Choudhury is a graduating medical student at Nova Southeastern University and will be starting her Psychiatry Residency at the University of Florida this July. She is particularly interested in the intersection between visual arts and medicine and the commentary this interplay provides.

SUNSET OVER LOWER LAKE DIANNE IN TALLAHASSEE, FL
Amara Ahmed
Class of 2023

FINALIST

I INTERNALLY CRIED WITH HIM

Stenia Accilien, Class of 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 emotion in the room was an idea far beyond my understanding. For a moment, I forgot I was a medical student—it felt like she could have been my mother. When my 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: "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.

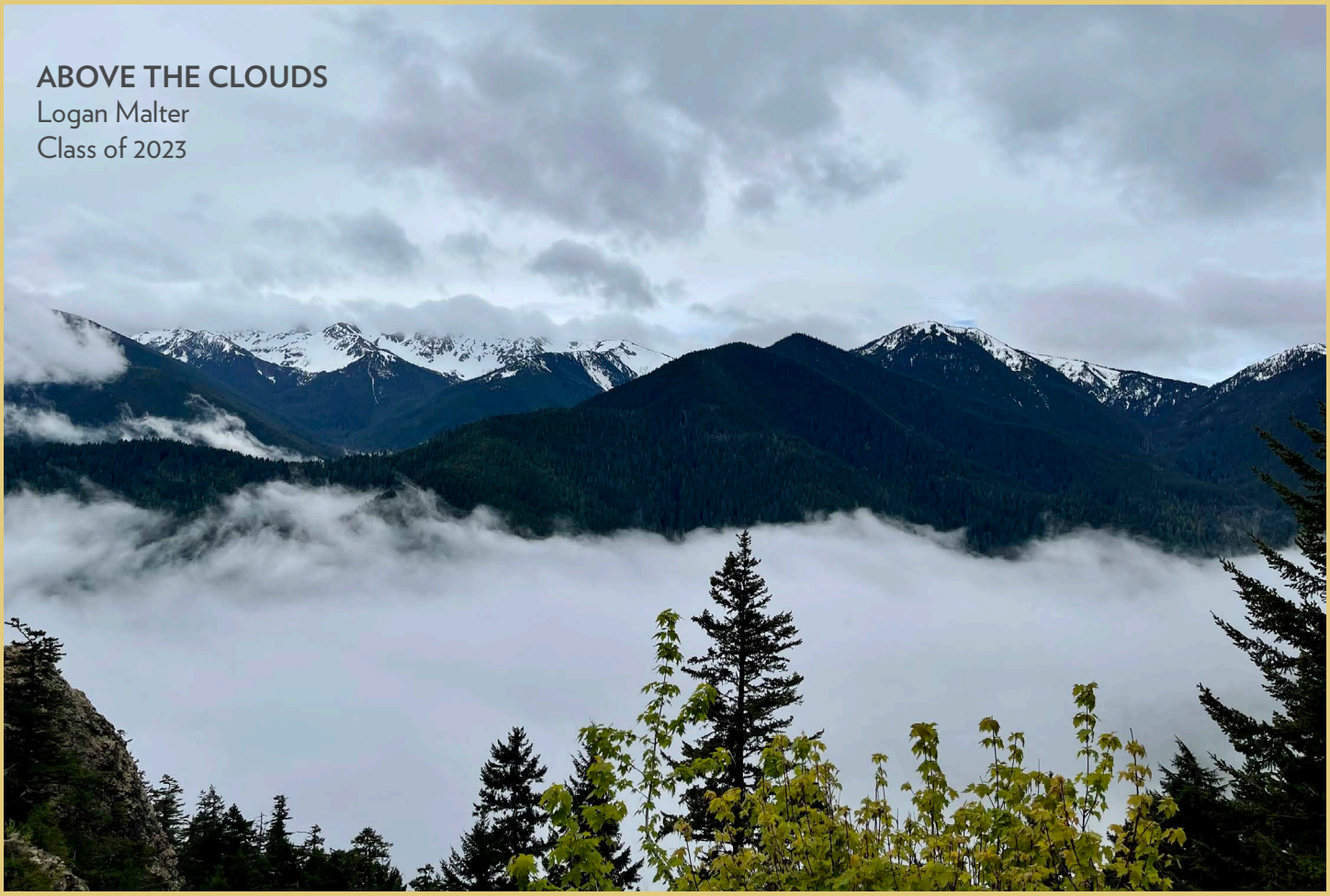
In the second week, a social worker located his parents in New York. Per family, they had not seen him for two years since he divorced. He was diagnosed with bipolar disorder and was on lithium for a while. He stopped taking it, despite it working well. His family then traveled from New York to Florida 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.



ABOVE THE CLOUDS
Logan Malter
Class of 2023

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

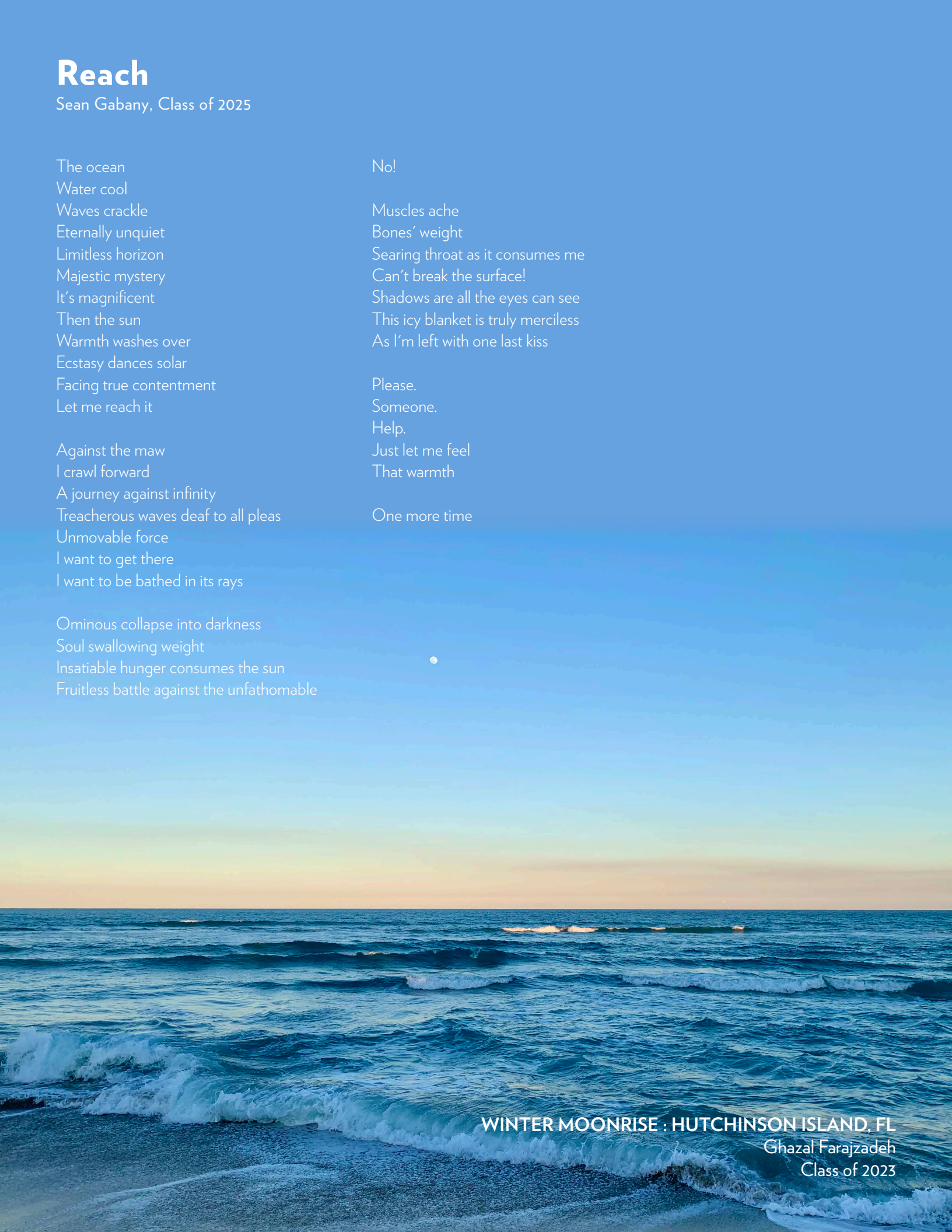
Ominous collapse into darkness
Soul swallowing weight
Insatiable hunger consumes the sun
Fruitless battle against the unfathomable

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



WINTER MOONRISE : HUTCHINSON ISLAND, FL
Ghazal Farajzadeh
Class of 2023