

# HEAL

Humanism Evolving through Arts and Literature



**THE GULF**  
Claire Ellis  
FSU Autism Institute

*Summer* • 2022



FLORIDA STATE UNIVERSITY  
COLLEGE OF MEDICINE

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### UTAH HIKES, ZION 2

Emily Gansert  
Class of 2024



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# Cento For My Younger Sister With Multiple Myeloma

Julene Tripp Weaver

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

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

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

I predict that losing you, specifically,  
will be too much to bear. You are a species  
that knows it will go extinct,

This is how I will let go of loss,  
by carrying you with me,

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

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



TRICOLOR  
Michael Hayward

# Hope IN MEDICINE

Hope Heldreth, Class of 2025

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

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

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

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

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

If cancer, hospice, and palliative care often end in death, where does hope fit in? Of course, there is always hope of remission from cancer or cure from a chronic illness, but this sense of hope for one's legacy, as I learned in hospice, led me to discover that hope also exists in research. While sifting through pathology reports recounting breast cancer diagnoses and entering many criteria into a database, it was hard not to think of these patient's lives. Although many of these patients lost their fight to breast cancer, their experience was changing, and potentially saving, the lives of future patients. By analyzing the outcomes of Her-2 positive breast cancer patients and comparing the different treatments and the extent of their disease, we were coming closer to a new standard of care. I found solace in the fact that hope never dies, even when people do.

There is no question where my passions lie, with a goal to balance realistic medical expectations with hope. For it is the feeling of my aunt's bony hand wrapped in mine, the opportunity to give a father the privilege of walking his daughter down the aisle—this human side of medicine—that drives my goals.

# The Thirty Minute Encounter

Narjis Mhaimeed

I walked in.

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

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

He soon spoke about Nepal  
like he was living there in his mind  
and new life breathed into him:  
A soul awakened.  
I was almost there,  
in the mountains with him  
amongst the clouds.  
The rush and noise of the corridors suddenly deafened  
and we could only hear the birds flying above  
through the fog.

It was my time to go. I waived goodbye.

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

Tender smile, curious nature.

Human.

My friend,  
he goes by Bhuwan,  
with a life far beyond the curtains of his hospital bed.

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

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

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



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**DIAGNOSTIC EYE**

Anna Kenney

Herbert Wertheim College of Medicine, FIU

# Margot

Allison T. Ong  
UC Davis School of Medicine

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

My friend Margot was despondent. Her lips quivered. Tears hummed and fell. Her eyes, normally the shape of almonds, folded themselves into little triangles when she cried. It was my junior year in college. We were sitting on a couch, taking deep breaths to calm the both of us, as she told me these things.

Margot was born in 1955. Between her age and her sadness, there were many moments I struggled to navigate with my kind, gentle neighbor. I grasped at any thought I could during the chaos, usually alighting on: *How did I get here?*

I met Margot in the springtime. On one of my brisk nighttime romps through the hills of Westwood with my beloved apartment dog, I saw something strange: scrabbling at the entrance to a nearby building was an uncollared white dog, even tinier and fluffier than the one dragging me around. She was impeccably well-groomed. A ragtag group of students surrounded the dog, nursing beer bottles and debating what to do.

As I joined them, someone let us into the building. The dog knew exactly where to go! She escorted us to the elevator, disembarked on the second floor, and sat primly at the door she knew by heart.

And so her queen arrived: Margot. The elevator doors opened shortly, presenting a woman in a long trench coat with wispy brown hair like cotton candy and an empty leash in her hand. She was weeping.

"Sophie, Sophie," she cried over and over, cradling her companion in trembling arms. Her apartment was small, dark, and brimming with unopened cardboard boxes. The scent of wine lingered in the air. Our new friend needed some help adjusting to Los Angeles, and a few of us were happy to give it.

Margot was joyful, compassionate, and eloquent. Her musical accent sung stories about a childhood in France and her training as a psychologist in Paris, at the height of her career holding seminars in both French and English. But that was

years ago, before a nasty divorce from her American husband. Now, she was learning how to be alone in America when everyone American in her life, including her son, rarely spoke to her.

I took her many places. First it was urgent care where, incredulously, they found one of her ribs fractured from a recent fall. Another day it was the federal building downtown where she hoped to secure a permanent visa. Another day we toured apartments. Eventually, she moved from that dingy college flat to a light-filled studio by the local art museum.

Many times we had lunch together, Sophie curled at our feet. Margot told me her stories and, in turn, bore witness to the slow realization that I wanted to go to medical school. She showed me Jewish music and how to use two different sponges for the meat and dairy in her kitchen. She met my family. She was a brilliant woman and, dare I say, a friend.

But the sorrowful days came often. I was happy to carry her shopping bags, that was easy enough. I was happy to attend Sophie's vet appointments or steam clean the carpet. But many problems – immigration, depression, drinking – were not easy fixes.

When dark thoughts threatened to drown her she fought desperately for air. I trailed my hands in the water from where I sat, hoping she would take hold. I was scared of her trauma. Of saying the wrong thing, of setting her off. Of probing too deeply about her estranged son despite knowing how much she wanted to talk about him.

Above all, Margot was stubbornly independent. She insisted I never bring her to the emergency room for a crisis. I had no idea if I was doing the right thing by holding my breath, trusting her word, hoping my presence was enough for her. Our relationship was an early glimpse into psychiatry, so even before starting school I had my trepidations about it. If I couldn't trust myself as a friend to do the right thing when someone told me they wanted to end their life, how could I trust myself as a doctor?

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Some say the most intimate specialties in medicine are surgery and psychiatry. Surgery struck me as concrete and precise in its invasion of the body. For hours I watched gloved fingers weave their way into the deepest, most precious parts of people they could never see for themselves. Healing was synonymous with touch. I retracted bowel, pierced fat, closed skin. I felt a woman's pulsating aorta and spoke to her the next morning. Surgery was indeed intimate, and tangible.



By comparison, psychiatry seemed abstract and imprecise, like surgery in the dark. I imagined myself striking painfully exposed nerves without my knowledge: saying the wrong thing, or at the very least not the *right* thing, hearing my voice echo back at me from caverns I was too afraid to enter.

On my first week of Child Psychiatry I was expected to shadow. Immediately, one of our first patients was a Spanish-speaking teenage girl who had impulsively swallowed a handful of pills. I almost shrunk into the curtains trying not to betray how fascinated yet terrified I was by the process of a psychiatric interview, how compassionate yet detailed were the questions asked about the details of her day.

Holy shit, I thought. These were all the questions I was afraid to ask someone.

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Navajo surgeon Lori Arviso Alvord wrote in *The Scalpel and the Silver Bear*, “the scalpel is used to bridge worlds.” I devoured her book for a surgery resident book club. Dr. Alvord’s journey was inspiring; she carved a pathway between Navajo culture and white culture, between doctor and patient, between air outside the body and air within the body. Surgery was an intimate process, one she practiced in the concept of *hozho* – walking in beauty. The surgeon in harmony with her team, her patient, and her world: *hozho*. Abstraction and beauty, two words I’d never applied to surgery before.

I imagined the psychiatrist wielding a scalpel of their own to carve a bridge between worlds. One of my first patients was a slim, pale girl hospitalized for infections and multiple vitamin deficiencies. Her medical history included autism spectrum disorder, depression, anxiety, and PTSD. Slipping into her room from the bustling, beeping hallway was like taking a swallow of cool air. She was extremely intelligent, with a quick and dry sense of humor. But her responses were brief, and she shut down every now and then. Especially when asked about her family. Over the next couple weeks, I tried building this bridge.

My favorite professors have been those who champion the skill of observation, those who in between images of chest X-rays and angry rashes make us analyze paintings or point out a hummingbird nest hidden expertly in a photo of our campus. So I let my gaze wander: over a monthlong hospital stay, what had this girl filled her space with? Percy Jackson books, anime character sketches, colored pencils, a Pokemon plushie... I had an idea.

I have one more question for you, I said at the end of our first meeting. Who was your starter Pokemon from the Sinnoh region?

Her eyes lit up. Maybe I could lay my first stone here.

As a rather young and addicted Nintendo DS owner, I had thought of my Pokemon as vibrant, emotive animal companions. I brought her a worksheet and a Pokedex, the atlas of all Pokemon from that region. Although she had difficulty processing emotions within herself, she had grown up watching cartoons, anime, and playing video games; she enjoyed the task of assigning emotions and personality traits to the Pokemon I gave her based on how they were drawn.

I challenged her. Every day she saw us, she had to choose a Pokemon that represented her mood. At first every Pokemon was “tired.” She picked the sleepy looking owl, the sleepy dragon.

Near the end of her stay, she had grown more comfortable with us. She picked a Pokemon that looked “sad” one day, and we explored that. She showed us the games in her Nintendo pack. And when she meditated with the help of my classmate, she shared with us a peaceful memory in the woods.

Healing takes time. I didn’t expect a magical change in this girl’s self-awareness. But I did see change in how she received our conversations. In two weeks we gave her more language for self-reflection and perhaps made her more comfortable speaking with mental health professionals. And in two weeks, I picked up other patients – many in crisis – each reinforcing what she had showed me.

## LIGHT AT THE END

Anna Kenney

Herbert Wertheim College of Medicine, FIU

To sit with a patient means to grab a chair and give them your complete presence, your curiosity, and your kindness. Even with pushback and silence, these conversations can be healing – while we keep in mind not to rush them. Healing is not a race. Even after surgery, the body must pull itself back into balance, *hozho*.

The pace of her healing was ultimately decided by her.

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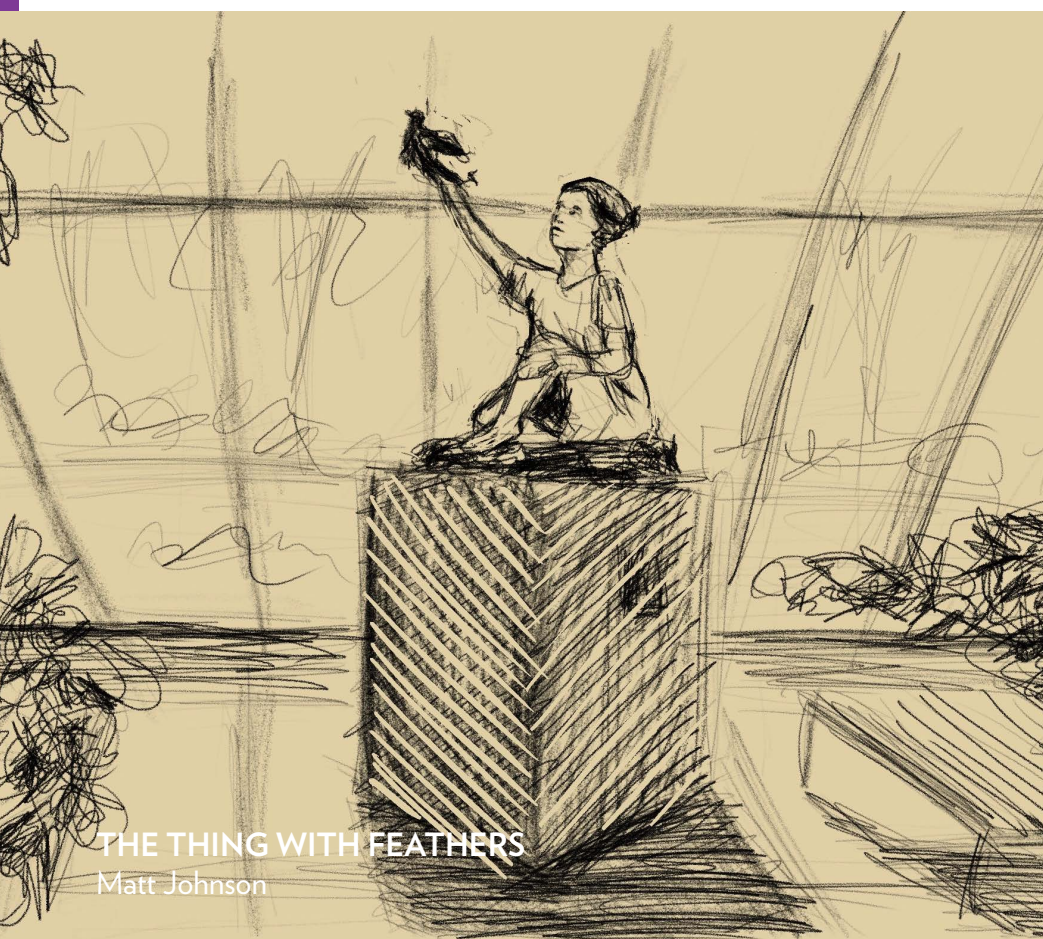
Margot and I reconnected last autumn over the phone: me on the sunlit patio of a coffee shop with my small pile of psychiatry books and Margot past midnight in Paris with her kitten. She had been stuck in France for personal matters throughout most of the pandemic.

It was wonderful to hear from me, she said. It told her that she had existed in America for a brief span of time, that somebody there remembered her. She had bright and detailed ideas for restarting her career. She had hope.

I am still trying to help her if she needs it. I'm still trying to listen. With our patients, and with ourselves, discussing emotions can be terrifying. But what many need, what Margot needed back then, is simply for someone else to take that mysterious first step and be present in the face of something unimaginable. A bridge that crosses worlds. A bridge built from the trust it takes to stand there together.

I asked many children on that rotation about their suicidal thoughts, their fears, their insecurities. For medical students it is a rite of passage to see every field and challenge themselves into the doctor, the human, they want to be. The gravity of difficult questions stays with me as I continue to ask them in different forms, in different settings, to different people.

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



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

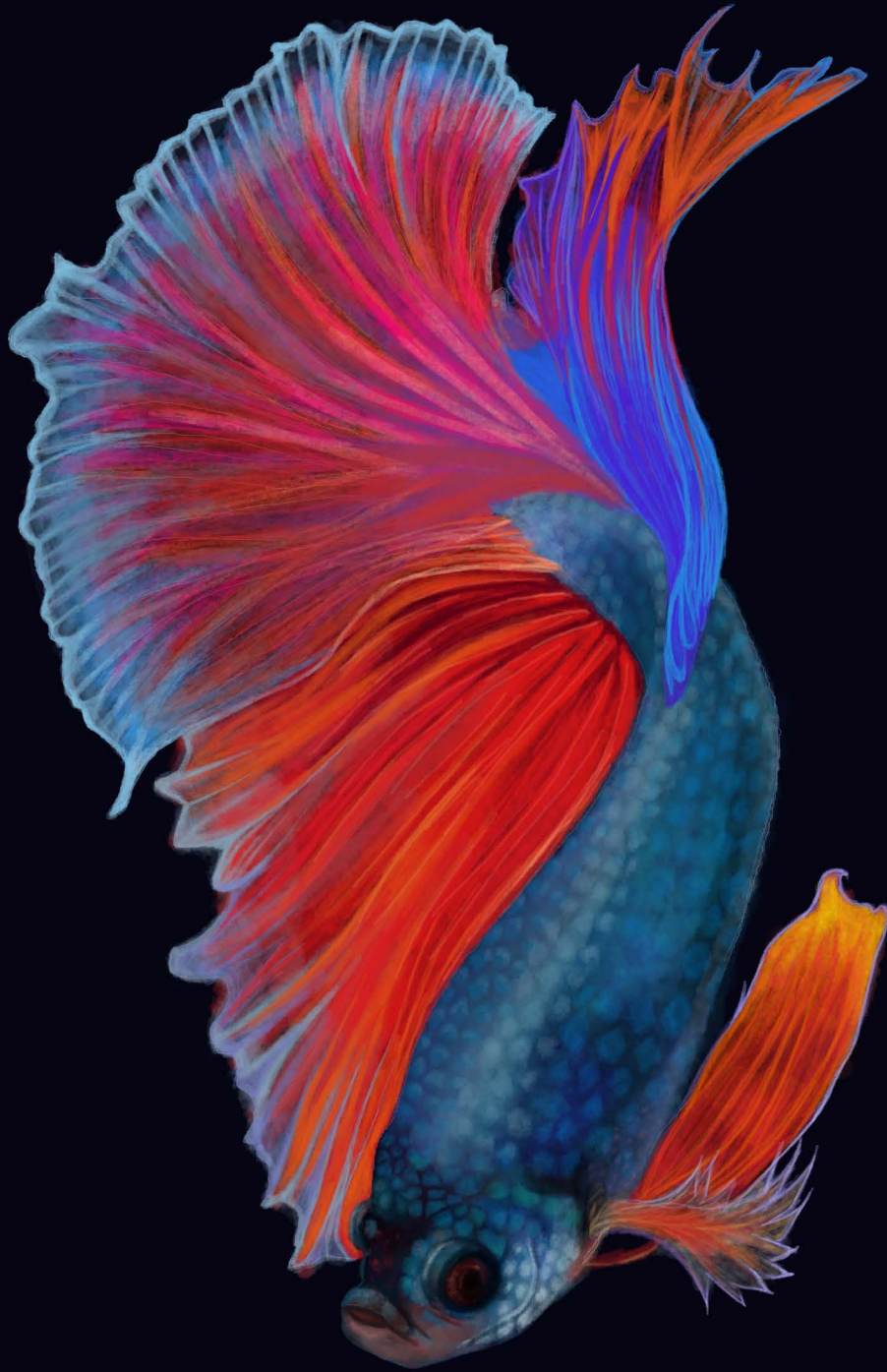
*Artist's Statement: Hope can be a floating idea held within the walls of our hospital or embodied in this bird about to take flight. As Emily Dickenson wrote, "[Hope] never stops—at all." I drew this still life after stumbling through the hospital searching for quietude and becoming ensconced in this outcome guarded by her statuesque optimism. Hope flies forth from her hands as she selflessly releases it into the world—a lesson she models for eternity. I hope to embody this practice of sharing hope through selfless acts of love in medicine as many who have walked these halls before me have.*



## JUST KEEP SWIMMING

Anna Kenney

Herbert Wertheim College of Medicine, FIU



*Anna Kenney is a second-year medical student at FIU Herbert Wertheim College of Medicine. She loves expressing herself through art and looks forward to incorporating this passion into her practice as a psychiatrist in the future.*

*Artist's Statement: I am proud to say that I completed all three of these pieces on my tablet during classes in my first year of medical school. Although I rarely have time to dedicate to my art anymore, these pieces are a reminder that I can always find some way to do what I love. Properly named, "The Diagnostic Eye," "Just Keep Swimming," and "Light at the End" represent what I can accomplish when I put my mind to it, even in the face of great obstacles.*





PENITENTIARY  
Michael Hayward

# HAPPY MEALS & END OF LIFE CARE

Sarah Smith, DO

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

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

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

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



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

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

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

“I can’t think straight,” my patient says, shaking.

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

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

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

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

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

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

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

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

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

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

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

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

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

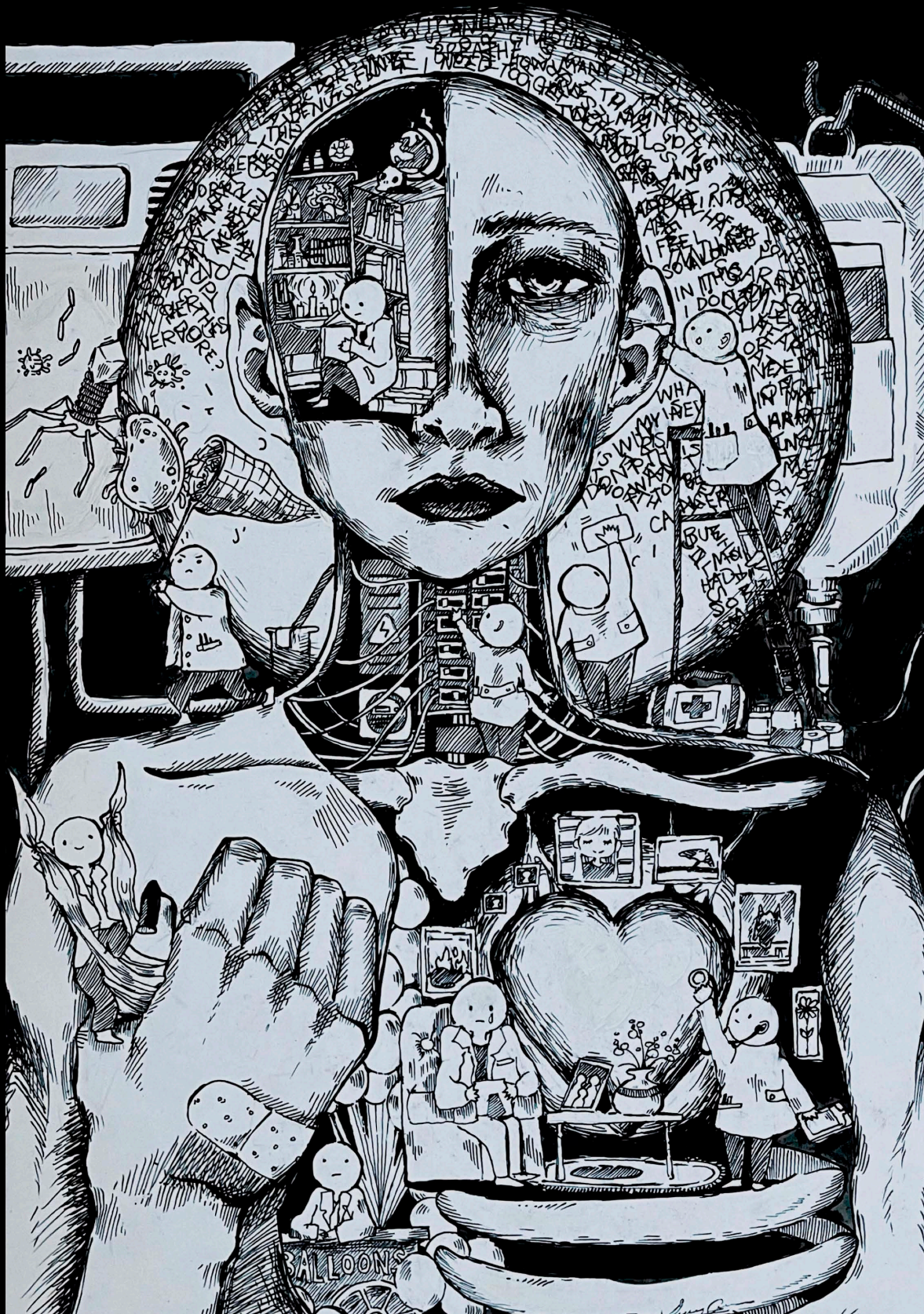
Sitting back at my desk, I can’t help but think about how, at the end, the only two things that really matter to my patient are who will take care of his beloved dog and his concerns about being comfortable. Does a whole complex life ultimately add up to that?

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

I respond, “I completely agree.”

*Sarah C. Smith is a board-certified family physician, an author, and a mother of two. She has also been published in Intima: A Journal of Narrative Medicine, Pulse, and KevinMD.*





## IT'S KIND OF LIKE Sydney Cabana

Sydney Cabana is a second-year medical student at the University of Florida interested in pursuing a career in child and adolescent psychiatry. She hopes to use visual arts as a means to help young patients understand medical conditions. "It's Kind of Like" was previously published in CALM.



# After the Ultrasound

Julene Tripp Weaver

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

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

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

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

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

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

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

UTAH HIKES, ZION 3

Emily Gansert  
Class of 2024