HEAL

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

ST. AUGUSTINE INTERCOASTAL
Emily Gansert

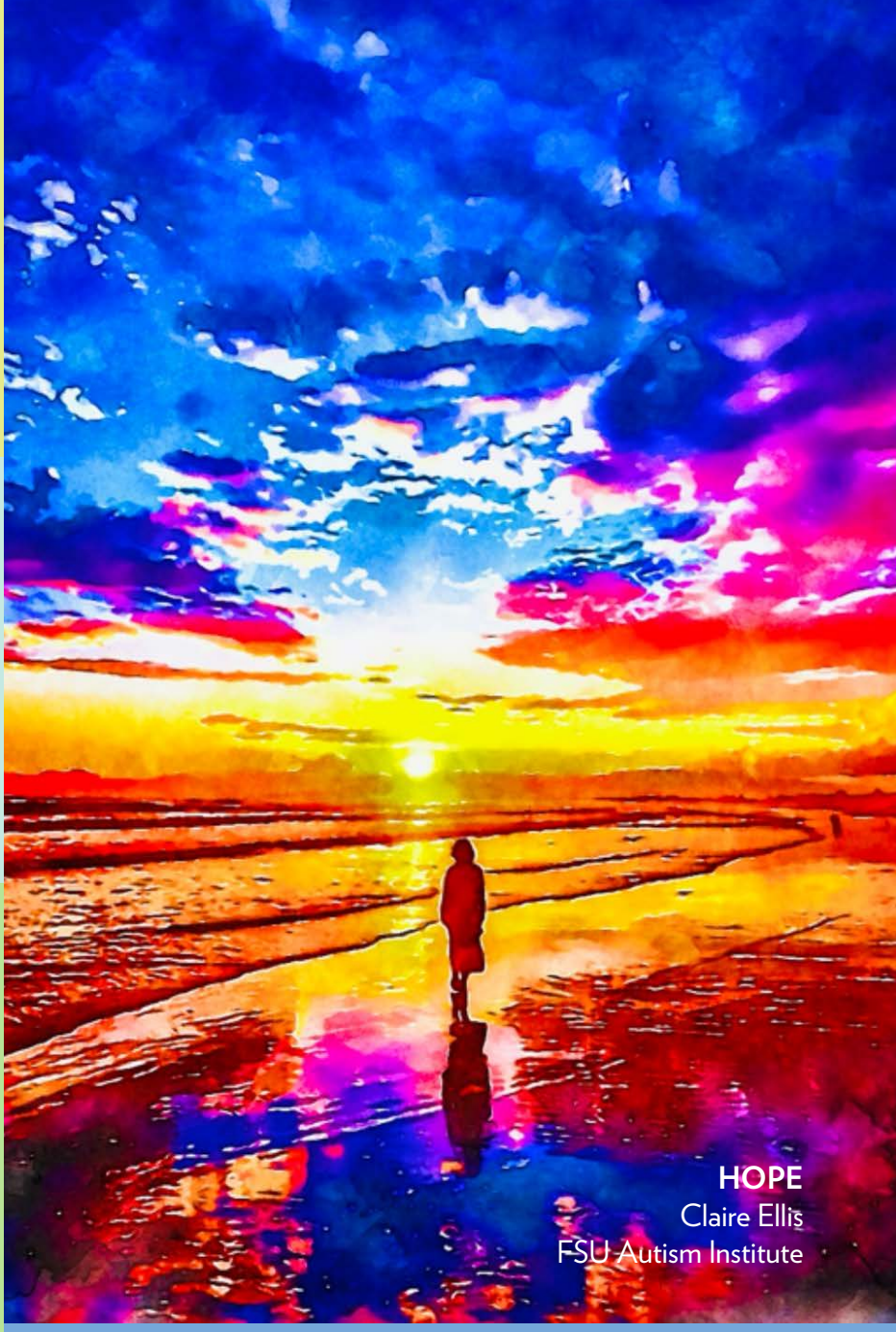
Spring • 2023

FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

PROSE

POETRY

ARTWORK



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Latissimus Dorsi Flap Reconstruction

Amy Haddad

At T-9 on the vertebral line, the tracks of a scar run through a tunnel, round a left-hand
bend on its route to the station stop on my chest.
The massage therapist flips down the sheet
to expose my back then asks, "Is it okay to touch
you there?" She lights her finger on the scar, so I know
where "there" is. I reassure her with anatomical
jargon, *the latissimus dorsi flap tunnels through
the axilla, inserts between the terrus major and
pectoralis major muscles.* The Latin comforts her.
Face down, I cannot see her fear, but feel her ease
up on the pressure on my left side.

At T-9 on the vertebral line, the tracks of a scar run through a tunnel, round a left-hand
bend on its route to the station stop on my chest.
The cross ties that kept the track intact
were stainless steel staples shot
through every half-inch. Even though
a site of high tension, the tissue tracks hold,
grow crooked with time, still vibrate
when a sneeze shudders through the walls
of the tunnel all the way to the end
of the line.

At T-9 on the vertebral line, the tracks of a scar run through a tunnel, round a left-hand
bend on its route to the station stop on my chest.
In a fitting room when I need help zipping up a dress,
a salesclerk obliges but I sense the pause in the zip
when she sees the scar. Her face appears
over my shoulder in the three-way mirror
a mix of pity, disgust, and a dash of curiosity.
She doesn't ask any questions, just zips up the dress,
and pats me twice on my shoulder.

Amy Haddad is a poet, nurse and educator whose work has appeared in The Annals of Internal Medicine, The Bellevue Literary Review, *and* Oberon Poetry Magazine. *Her first poetry collection,* An Otherwise Healthy Woman, *was published by Backwaters Press in 2022.*

HEAL en español

Esperabamos en el lado

Elise Solazzo

Estábamos al lado de la carretera donde esperábamos a los bomberos para que liberaran a nuestro paciente del coche accidentado. Fingimos que no mirábamos a un hombre morir.

Los SEM, como grupo, son maravillosos en esto, y fuimos trabajadores del SEM buenos y entrenados. No sé exactamente el origen de esta cultura, pero tenemos mil dichos agudos que significan lo mismo: cálmate, especialmente cuando el paciente de verdad está enfermo.

"No es su emergencia."

"Despacio es suave, suave es rápido."

"Lo primero que hay que hacer en un paro cardiaco es tomarse el propio pulso."

Repito, hay mil dichos, pero ninguno de ellos advierte cómo se siente. Ninguno de ellos te prepara para el día en el que te quedas de pie, al lado de la persona moribunda. Pensar que reíste con tus amigos cuando un hombre estaba muriendo, porque uno nunca se puede preparar para este día. Si levantas el ánimo con palabras jocosas a quienes dan gritos ahogados al escuchar esto, no son risas verdaderas. Tus bromas son sofocadas, como las piernas de tu paciente debajo de los pedales. Aún cuando el tripulante de la ambulancia hace ruido y habla de forma escandalosa, en verdad habla solamente en susurros, especialmente cuando camiones pasan a toda velocidad. Entonces, ¿que más se puede hacer? ¿Llorar? No, esa no es una alternativa. Eres profesional y tienes un trabajo qué hacer. Hay que fingir estar más que normal para trabajar, si quieres alguna esperanza en salvar al hombre que todavía está atrapado en el coche y a quien todavía no le has visto la cara; el hombre a quien miras muriendo mientras ríes.

Elise Solazzo has been an EMT based in Massachusetts since 2019. She graduated from Brown University in May 2022 with a degree in Slavic Studies and plans to begin medical school in Summer 2023.

CABO ARCH
Lauren Hopson
Class of 2026

HEAL en español

La confianza del doctor

Miguel Rodriguez, MD

Dicen que la vulnerabilidad de los hombres es preciosa,
que sus egos son altos, pero se paran encima de bloques inestables.
¿Y qué piensan sobre la confianza del doctor?

¿Amo a mis profesores,
pero como encuentra uno la confianza del doctor?

Una genio me dice:
"Ponte la bata blanca, córtate el pelo, ten tono de voz más profundo."
¡Perfecto! Ya lo hacemos, y si ayuda, pero no cambia la inseguridad interna.

Uno que sabe algo, pero no se puede recordar todo.
¿Qué le da el poder para darle instrucciones a una abuela con mucha más vida, muchos más desafíos, a confiar en la opinión de un residente de medicina familiar de 32 años?

Pero ahí encontramos el secreto:
El Doctor de Confianza es el que escucha,
no el que se lo sabe.
El doctor de confianza aprende sobre medicina a través del paciente,
no se critica al no saber la respuesta.

La medicina cambia con nuevos medicamentos y nueva tecnología, pero los principios son antiguos:
Amar,
Escuchar,
Ayudar,
Y estudiar para toda la vida.

Miguel Rodriguez is a Family Medicine resident at Loma Linda University Hospital. He has struggled with confidence but continues to grow into a doctor for the people and for social change.

Riding The Everlasting Rollercoaster: Living With Alternating Thyroid Disorders

MINA ERIK

Mina Erik is a second year nursing major at Ramapo College of New Jersey. She enjoys practicing different forms of art in her free time such as calligraphy, painting, and digital illustration.

THE 9TH 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.*

This year's essay contest prompt: *Throughout our careers in medicine, we are exposed to various ideologies and mental frameworks. Describe a time when you were witness to a new perspective or idea, and how this has shaped your view of medicine.*

1ST PLACE

Franziska Leutsch, Class of 2024

It's 6 am on a chilly Monday morning. I watch the sky begin to pinken through the small, austere windows of the resident's workroom. The second-year night pediatrics resident is giving morning sign-out to the team, going down the list of the complex patients on the floor at a seemingly breakneck speed. Hastily scribbling notes on topics I need to read up on later, I struggle to keep up, a feeling every medical student on their first day of a new rotation knows well.

My PATIENT

"No changes with her, continue morphine escalation," the night resident says, already on to the next patient. The day shift chief resident interjects and looks at me pointedly, "This will be a good one for you to present on rounds." I nod and place a star next to her name: 3-day-old Baby A with NAS, admitted to the floor for severe opioid withdrawal.

When sign-out is finished, the intern lets me know I should start pre-rounding on my patient. "My patient," a phrase I'd never heard before. I'm not sure if I will ever feel like she is *my* patient, but I resolve to do the best I can for her.

A quick chart review shows me that Baby A is in the throes of withdrawal. She is inconsolable, feeding poorly, and has been started on escalating morphine, despite being barely 72 hours-old. Her vitals show me she is in pain, with intermittent tachycardia and tachypnea. Beginning to paint a mental picture of her clinical state, I quietly slip out of the workroom, ready to meet my first patient.

As I enter, my eyes taking a second to adjust to the dim lighting, I see a newborn swaddled in a generic hospital blanket, uncomfortably squirming and sporadically letting out small wails. I carefully unwrap her for my physical exam, noticing significant hypertonicity. After I am done, I gently swaddle her again to give her some relief.

Making my way back to the workroom, my heart aches for this little baby, going through a bad withdrawal in a sterile hospital room. Not yet adjusted to the novelty that she is my patient, I am determined to be her support throughout the next two weeks.

I present Baby A on rounds, along with my plan to continue morphine escalation every 12 hours, and a head ultrasound to rule out intracranial pathologies. The team agrees, and thus goes my first day with my first patient.

Over the next week, gradually, the reference to Baby A as "my patient" feels less incongruent. The phrase becomes less foreign to me, and slowly I begin to embody it. Baby A continues to need morphine escalation for her symptoms, and her feeding difficulties continue. Every day before pre-rounding, I look up her I&Os and weight and check her suck reflex, hoping that she is managing to feed herself better. When she continues to have inadequate PO intake, baby A requires an NG tube which I help place. Every day on rounds I present the plan to Baby A's grandmother when present. I spend time in her room between patients, holding her and rocking her to let her know that she is not alone. I realize that for Baby A, medical management is as important as the touch of someone who cares about her.

During team switching at the end of the first week, the previous resident says, "Oh, that's her patient, she knows all about that baby." My heart swells as I realize the team firmly considers Baby A to be my patient. I repeat the words to myself. *My patient*. What a vast responsibility, yet gift at the same time.

Finally, over the weekend, Baby A begins to stabilize. Her hypertonicity and inability to be consoled start to lessen, and the morphine dose is stabilized. During the next week, she continues to improve and begins a morphine wean. I spend as much time with her as possible, knowing that my stretch on inpatient pediatrics is drawing to a close. On my last day on the wards, I go to say goodbye to my patient and her grandmother.

I hold little Baby A for the last time. She looks at me quietly with her big blue peaceful eyes, saying so much without ever uttering a word. I quietly pray over her, wishing her a good life full of bountiful joy and everything she desires. I thank her for being in my life, although shortly, and promise her I will always remember her and the lessons of compassion, empathy, patience, and the value of kindness that she taught me.

Her grandmother comes in. "Thank you, doctor," she replies, "you have been taking such good care of A." Automatically I remind her that I am just a medical student. She stops me and earnestly says, "To me you are her doctor. You have done so much for her, when she is grown up I will tell her about the young doctor who spent so much time making sure she felt safe."

I nearly tear up. This is the first time I have heard those words. It means so much to me to even be involved in Baby A's care, much less be recognized for it. As I leave Baby A's room, I take one last look at her sleeping calmly in her bassinet, trying to memorize the way the shadows fall on her face. To all my future patients, I resolve to approach and treat them in the same comprehensive, caring, and empathetic way that I first learned with Baby A.

"I said goodbye to my patient," I tell the team. The first time I have said "my patient" and believed it while understanding the responsibility and privilege that it holds. The first, but not the last time. As I leave the rotation, I look forward to the incredible honor of a lifetime of saying "my patient." Thank you, Baby A.

ROSEMARY: HELP IS HARMFUL WITHOUT CONSENT

Arwyn Hill

Arwyn Hill is a saxophonist and freshman music education major at the FSU College of Music. Their work was inspired by experiences during the pandemic.

On Being a Patient

Parastou "Mandy" Shahzeidi, Class of 2024

It was the first day of my inpatient internal medicine rotation and I felt as excited as ever to be in the hospital, participating in rounds. "How's your day going?" I asked automatically, and in a cheery tone, as I entered my first patient's room.

"How do you think it's going? I'm in the hospital," the patient snarled dismissively. I stood there, a deer in the headlights, completely caught off guard. While I figured that her intentions were not to be rude or malicious, I'd be lying if I said I didn't think about moving away slowly and never looking back. Instead, I considered what it would be like if it were me laying in that hospital bed. My heart immediately sank as I thought about the implications of my seemingly innocuous question.

From her perspective, I pictured being in an unfamiliar environment, constantly bombarded by unfamiliar faces spewing out medical jargon, leaving me more confused than before. Never knowing when the next needle stick was coming. To me, they were colleagues, but to her, vampires out to retrieve her blood at all hours of the night. Understandably, it wasn't going great, who wants to be in the hospital? She was simply stating the obvious, something that I had failed to consider as a stranger looking in from the outside. Of course, my exaggerated dark fantasy isn't the experience for every patient — I'd like to think it never is — but I suspect that that would be wishful thinking.

I am privileged to work in a profession where we are provided the medical knowledge to treat any physical issue to the best of our ability. However, amidst a prevalent "I can fix it" attitude, it's possible to lose the empathy and emotional connection that differentiates us from a computer going through a protocol or algorithm. As hospital staff, we are expected to leave that room and go on with our lives, on to the next patient, each new conversation further detaching us from the previous, until we go home to our families and fully disconnect for the night. And when we come in the next day, well rested from a good night's sleep in our own bed, we can fall into the trap of assuming everyone else has decompressed as well.

But what about this patient who has been stuck in her hospital bed that entire time? I thought about the monotonous hours upon hours she has spent in that barren room, without much to keep herself occupied aside from her own thoughts and situation. Could she have been ruminating on something said to her, or an ambiguous test result from the previous day, as I walked in? Should she really be expected to greet me with a smile and enthusiasm while fear and uncertainty linger in the air? These were sobering questions that I pondered, but ones that humbled me enough to stay in that room.

I pulled up a chair next to the patient's bed and took a moment to really look at her. In that instant, I realized that there's so much to learn about a patient aside from what they say; her appearance, antsy body language, irritable tone, poor eye contact. To me, what makes truly empathetic physicians is their ability to read the situation and adjust ways of communicating to best fit what the patient needs in that moment.

It became clear that this patient was distressed and unhappy; maybe it had less to do with the illness that got her here and more with the baggage that comes along with being in the hospital. I got on her eye-level, gave her my undivided attention and said, "Let's forget about the medical stuff for a minute. What else is bothering you today?" She immediately looked up at me with a surprised expression. "Well, since you asked, I'm worried about my dogs at home, my family is driving me crazy asking how I'm doing every 5 minutes even though I feel fine, I'm bored as ever in this room and I'm stressed just thinking about how big of a hospital bill I'm going to get once this is all said and done." We looked at each other silently for a moment and I said, "You forgot that the food here is terrible." To my surprise, she broke out into a smile.

From then on, her demeanor and our interactions underwent a complete transformation. While we used humor as a defense mechanism, it also opened the door to having serious conversations about the psychosocial issues she was going through. I learned a lot from this patient. The chief complaint on her chart read 'chest pain,' but there was so much more to the patient than that.

While it constitutes my workplace, the hospital is inherently an unappealing place to be in a patient role. By giving patients an invitation to speak their mind beyond the medical aspect of their care, we can make this scary place a little less uncomfortable; whether that's with an extra pillow, sneaking a diet coke from the doctor's lounge, a little humor, or just being a body to vent to.

Left After Cancer

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

More left hands than right
preserved amid dirt and grass.
I wonder if one of theirs
knew loss so young
like this. I run my tongue
over porcelain teeth—a fused
trinity, a reunited front that I use
to smile at the world.
I think about friends long gone, and those
dangling in the balance,
swinging from strands
of silver wigs. We grow old before we ever
get to be young. In sunlight
blue extruded veins latticing
the backs of my hands—left and right—
all but disappear.
I sweep downy hairs from the nape
of my neck, muse
another hundred times today
about cutting it off preemptively—
a loss foretold and calculated,
one more thing it cannot take.

TRANQUIL
Claire Ellis
FSU Autism Institute

SANTA LUCÍA, FRANCISCO MORAZÁN, HONDURAS

Benjamin Linkous, Class of 2026

The Global Health Collaboration Project (GHCP) is a research partnership between FSU, FAMU, Universidad Nacional Autónoma de Honduras, and the SENACIT (Ministry of Science, Innovation, and Technology) of Honduras with the primary objective of improving health care in rural Honduran communities through stakeholder-guided initiatives. This photo is from Santa Lucía, Honduras, one of the rural municipalities in which we conducted a pilot survey in March 2023. The trip provided me with insight on how I can incorporate cultural cognizant care and research within communities across the globe.

ABANDONED SUGAR MILL
Justin Frankle

3RD **PLACE** | Humanism in Medicine Essay Contest

Preferring the TRUTH

Jessica Laenger, Class of 2024

Equipped with my stethoscope and a diagnosis of "altered mental status," I hurried to the Emergency Department to evaluate one of my first patients on my internal medicine rotation. I knocked on the patient's bay door and entered to find a slight, middle-aged woman with sun-bronzed skin and buzzed hair, resting soundly in the fetal position with oxygen flowing and IVs adrip. She did not stir as I walked in and called her name, her chest continuing its rhythmic expansion-contraction cycle as if of its own accord.

I mustered through an initial interview which was severely limited by the patient's lethargy. Her responses to my questions alternated between "I don't know" and the deep inhale and exhale of sleep. By the end of the interview, I had gathered that the patient was tired and exasperated and that she had recently used methamphetamines. Following my initial interview, in nearly comedic, textbook-style fashion, my attending was able to elicit a much richer history than my own. By that time, several tests and images had returned, the patient had been admitted, and we started her on antibiotics for sepsis secondary to pneumonia.

I rounded on this patient daily, and it was rewarding to see the glow of life in her brown eyes brighten with each visit. Each day I heard parts of her story—she did not have a stable living environment, her fiancé had passed away suddenly last year, she was no longer in contact with her children, and she was dealing with chronic pain due to a motorcycle accident. My heart broke for all this woman was bearing, and it made me even more intent on caring for her with tenderness and compassion.

Photo at top of page:

Justin Frankle is a graduate of the University of Maryland currently working as a Software Engineer for L3Harris.

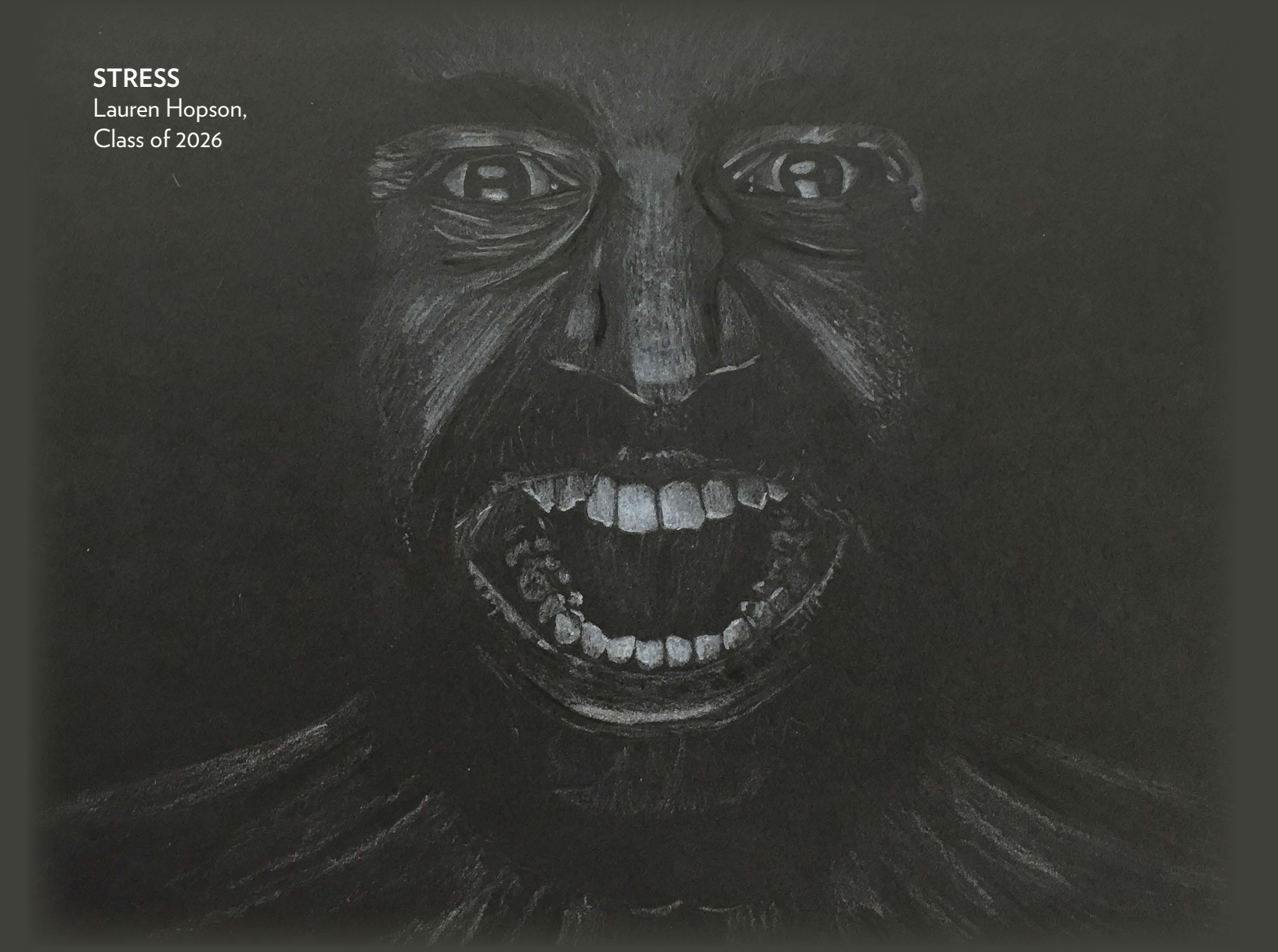
Heeding this patient's every wish seemed like the easiest way to communicate to her that I cared for her (though I would not generally endorse this approach). This proved to be a difficult task as each day the patient's concerns only increased. For each issue that was resolved, two new ones seemed to arise, and there were several instances that led us to question the patient's reliability as a historian. It was around the fifth day of this patient's stay that I began to experience some compassion fatigue (and became somewhat scandalized at myself for this lack of charity). The enthusiasm, authenticity, and compassion that had flowed so freely from my heart in the first days of this patient's stay had seemed to evaporate, but my desire to accompany this patient and communicate that she was cared for remained.

The following day, full of questions about how to care for patients in charity and truth, especially when it felt forced, I rounded on her with my attending. The patient said she was not feeling any better, complaining of neck, back, and chest pain, and she was concerned that something serious was going on. We explained that we were heartened by the progress she was showing according to the trends of her test results, but we understood her concerns and would get her some additional pain medication. After we walked out of the room, my attending said something along the lines of, "The patients that you think may be fibbing or exaggerating are the patients for whom you have to go above and beyond so as to not miss something." My jaw dropped. This was revolutionary to me.

You tell any seasoned clinician this and they say, "Well, of course!" but this was a totally new proposal to me, one that helped me breathe again. No longer did I have to white-knuckle myself into feigning affection for each patient I saw. It was ok to have an instinctive reaction and to acknowledge this. In fact, it was important to recognize my reactions, when my heart leapt or sank, because it was in acknowledging that I didn't have an automatic affection for this patient that I was better able to care for her, by running that extra test or doing a curbside consult to ensure that nothing was missed. This was done with humility and a desire that my affection grow for this patient as for every person, aware that in that moment, I could only ensure that this patient received the best care through the help of additional medical tests and other colleagues.

Through my experience of caring for this patient, I saw again how vital it is to always call things as they are, even when I wish things were different. As my good friend says, we must prefer the truth of what is in front of us, whether a circumstance, a patient, or ourselves, to our own ideas or our attachment to our ideas about these things. I've come to see that I don't need to be embarrassed about the brokenness that I see, in myself or others, because it isn't up to me to save everyone. This recognition that I am not in control frees me from feeling suffocated by a sense of total responsibility for everything on one hand and from feeling a need to say everything is fine (whether it is or not), to remain the regal Queen of the World in total control, on the other. It's in acknowledging brokenness where it is present that allows us to work starting from reality (not merely ideas), without either blind optimism or bitter cynicism. In calling things as they are, we can reasonably hope and enter true communion with others, asking for help and awaiting and facilitating the healing that can come through our hands.

In my rotations this year, I'm incredibly grateful not only for the patients from whom I've learned, but also for the physicians with whom I've worked who care deeply for their patients and love what they do. It is a great gift to get to watch them work, ask them questions, soak in their wisdom, and put my feet in their footsteps—to see what they see and imitate what they do until it becomes my own. Not as a simple, parrot-like imitation of a master, but by allowing what I've witnessed to take on a unique resonance in my own humanity.



STRESS
Lauren Hopson,
Class of 2026

Clinical Rotations

Davin Evanson
Drexel University College of Medicine

Clinical rotations, a time of great despair
Endless hours spent on wards and in the clinic
Yet through the exhaustion and the constant care
We learn the art of healing, and begin it

We see the sick and injured, face to face
We hold their hands and offer words of hope
We witness life's most precious moments, its highs and lows
We learn to treat the body and the soul

We toil through grueling shifts and sleepless nights
But through it all, our passion for medicine grows
We are the future doctors, ready for the fight
To heal the sick and ease the suffering, wherever it goes

So bring on the clinical rotations, let us learn
For we are the ones who will heal and make a difference, in our turn

Davin Evanson is a third-year medical student at Drexel University College of Medicine. After learning that his great-grandfather wrote poems, Davin found a passion in expressing his medical experiences through poetry.

WHAT Knitting MEANS TO ME

Debra Danforth, DNP
Director, Clinical Learning Center

I first started knitting as a result of a leadership course I took about 10 years ago. We were trying to find something that would help with work-life balance since work was all I seemed to do. So I started out making scarves at the end of each class, then I was told to knit during class. To my amazement, knitting helped me relax and pay more attention to what was being presented. Knitting also taught my brain that I didn't need to come up with a solution for everything discussed or presented to me—that it was okay to just listen.

After the leadership course I continued my knitting practice—knitting at least 30 minutes after work every night. I made hats for the homeless, continued making scarves for everyone, and then branched out to blankets, boo boo bunnies, and prayer shawls. While completing my doctoral degree, my faculty continued to encourage me to knit during class because they knew it would help me stay focused. Most recently, knitting helped me maintain my mental health while taking care of my mom on Hospice. It was very therapeutic. During this time I had a knitting box sent to me every month. Each box contained a new project—something I had never knitted before. This forced me to branch out and learn how to do different projects from fingerless gloves to several shawls. This was the best therapy I could have received.

So when you see me around, I'll likely have a project connected to my backpack, or you will see me in a conference or meeting knitting away. It's great for work-life balance.