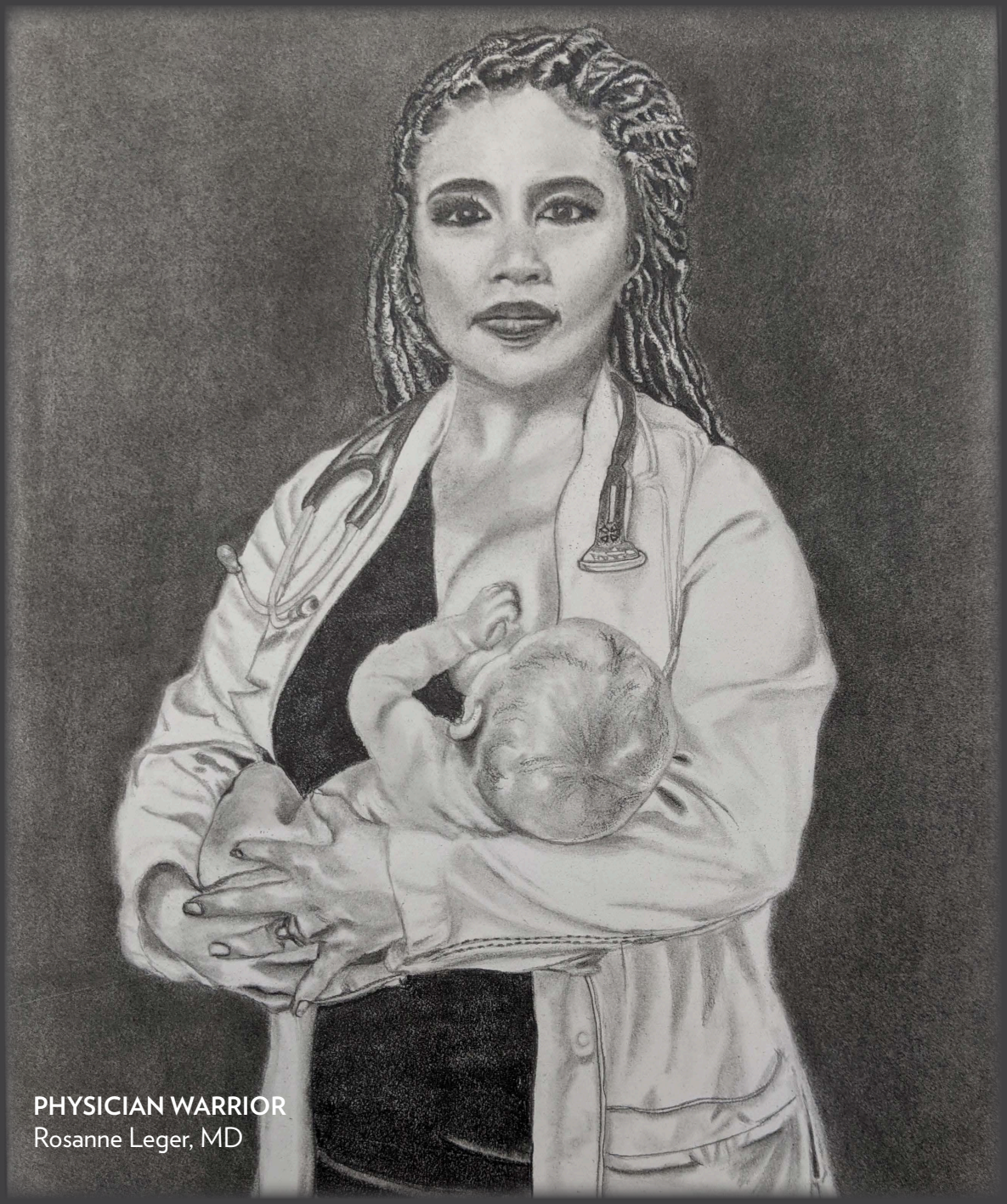
HEAL

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



PHYSICIAN WARRIOR
Rosanne Leger, MD

Winter • 2023

FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

PROSE

POETRY

ARTWORK

On the cover: Dr. Leger graduated from Meharry Medical College in Nashville, TN, and did her Family Medicine residency at Halifax Health Medical Center in Daytona Beach, FL. Dr. Leger works as a hospitalist and in her free time enjoys exercising, drawing, painting and spending time with her family.

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FUTURE HOPE

Ramiz Kseri, MD
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Artist's Statement: "I remember seeing this picture from The New York Times shot by Sarahbeth Maney and immediately knew I had to draw it. It just felt like hope . . . like future! This is Leila Jackson on the first day of the Supreme Court confirmation hearings for her mother, Judge Ketanji Brown Jackson. This was created on the app Procreate using an iPad Pro with Apple Pencil."

On ECMO and Ubers

Hannah Decker, MD

It had been a long week. Our attending smiled wanly as we made evening rounds in the intensive care nursery, saying to nobody in particular, "If we are going to put this baby on ECMO, it would be ideal if it wasn't in between the hours of midnight and 4 AM."

It only took me a few years of residency to learn that hoping to sleep through the night is dangerous – the more strongly you yearn for uninterrupted sleep, the nearer the certainty it won't happen. So, I was unsurprised when my phone buzzed me awake that night with a text message. "We are going to proceed with ECMO shortly if you want to come." I splashed some water on my face and changed out of my pajamas. Despite knowing how dangerous it is to drive while tired, the convenience of taking my own car to the hospital was hard to shake. But, it was the first rotation of a new academic year and I had promised my husband I would be more cautious. I called an Uber, watching instructional videos of ECMO cannulation while I waited for it to arrive. Already dreading rounds the next morning, I tried my best to get a few more minutes of rest en route, but I was unsettled thinking of the baby and his family.

To be honest, I was unsettled by much of my pediatric surgery rotation. If I truly stopped to think about the situation of many of these families who lived in the hospital, caregiving for seriously ill children, it brought me to my knees. During the days, I tried to avoid this line of thinking, hustling to take care of our large census of children. But at night, my patients' names and faces swam through my mind. A teenager with a nasogastric tube in for weeks, calmly doing homework in the hospital armchair. A mother, eyes welling up: "Do you really have to do the surgery tomorrow? It's my birthday and I just don't want anything bad to happen." A young girl in the pediatric intensive care unit, swollen with steroids, whose skin shredded like wet Kleenex when we placed a central line. A baby who swallowed something not meant to be swallowed. Her grandmother's face when we told her it meant an emergent operation. A precocious teenager with metastatic disease who wanted to become a doctor like me. A usually stoic fourteen year-old, immunosuppressed from treatment for cancer, crying big, salty tears after we completed a bedside incision and drainage – from the pain, or perhaps from the unfairness of it all. I have a fourteen year-old brother. He is usually stoic, too.

When I arrived that night, the neonatal intensive care unit was swarming with activity. Each team member was diligently doing their job, in the middle of the night, to give this little one a shot on what can only be described as a very challenging first day in this world.

Our team proceeded with cannulation under the heat lamps of the NICU. Even with loupes on, the beating anatomy seemed impossibly small. Finally, the circuit was connected. The team began to breathe a little easier and, eventually, dissipate. Weary, I called an Uber home. As the car started, I began to doze off. A few minutes into the ride, I was awoken by a question. "Do you work in the children's hospital?"

I explained that I was a surgical resident working there for the month.

"Do you know any of the pediatric perfusion nurses?"

I was startled by the question, having just spent all night closely working with them. "Yes, I know some of them. Why?"

He looked at me in the rearview mirror and the words tumbled out as we drove through the sleeping streets. As it turns out, a long time ago, his infant son had been on ECMO for many days. The perfusion nurses were a constant accompaniment at the bedside. He had gotten to know them as they carefully watched and troubleshot the machine keeping his son alive – and in turn, they had grown to love his son. He smiled as he told me how they had burned a CD of music that the family loved and played it for his son so that he could feel at home, even when his parents couldn't be there.

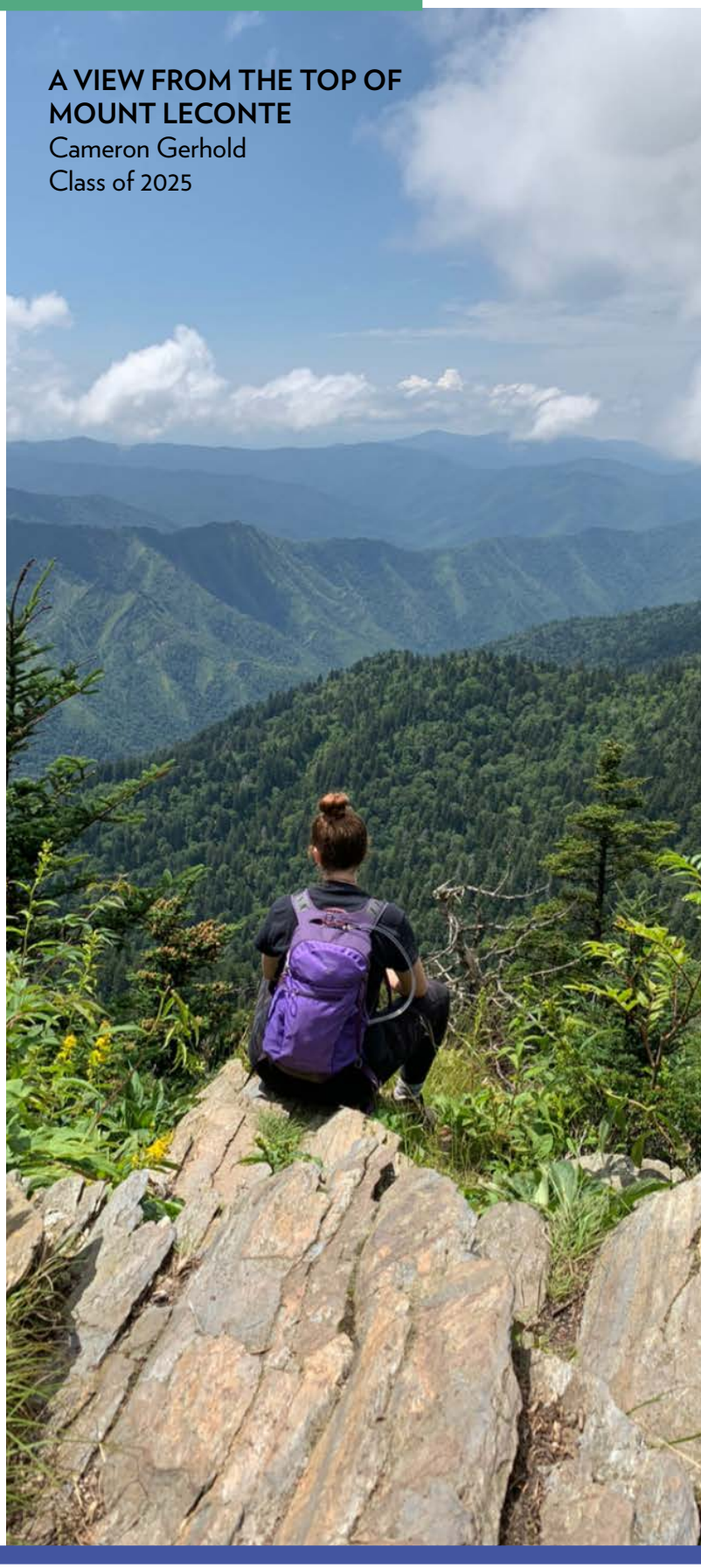
The man grew quiet, as if deciding to tell me more. "My son died fourteen years ago this month. Every year, for fourteen years, something happens during this season that makes me think of him – remember him. This year, it is you, getting in my car."

He thanked me for learning how to take care of sick children. I thanked him for sharing the story of his son with me. Soon, the ride was over. I slowly made my way up my stairs and into my bed.

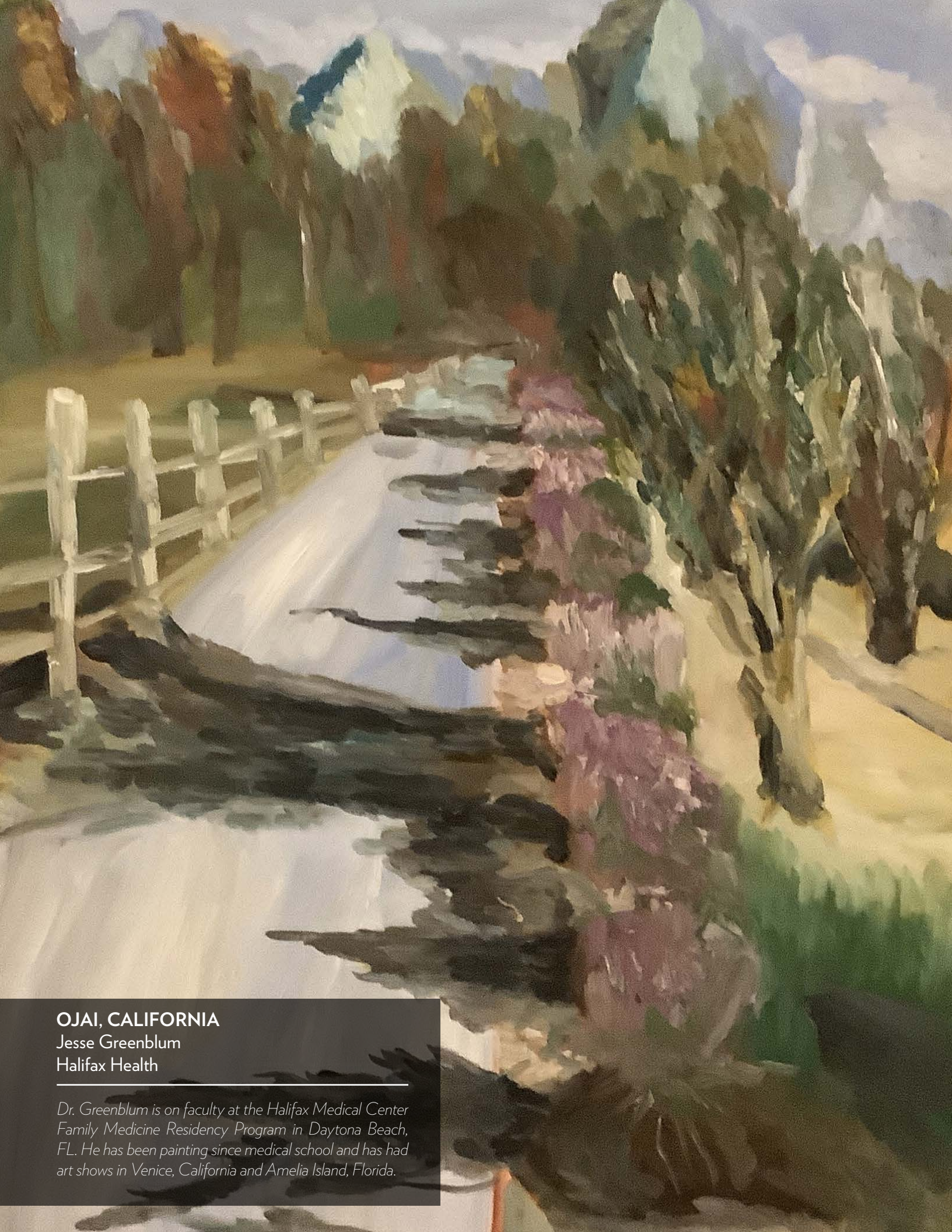
The next morning back in the NICU, I relayed his words to the perfusion nurses. They remembered him. They had loved, and subsequently mourned, his son all those years ago. His name and face swam in their head, too. They told me their stories over the soft whirring of this ECMO circuit, for this baby, loved by these parents.

These kinds of moments are the ones we carry. The ones when the universe reminds us – even though it is a struggle, and we are exhausted, and our patients break our hearts – why we do what we do. For the life in front of us now. For the faces and names that swim in our heads. For the families of those faces and names who remember.

Hannah Decker is a fourth-year general surgery resident at UCSF interested in improving surgical care for vulnerable populations and embracing humanism in surgery.



A VIEW FROM THE TOP OF MOUNT LECONTE
Cameron Gerhold
Class of 2025



OJAI, CALIFORNIA
Jesse Greenblum
Halifax Health

Dr. Greenblum is on faculty at the Halifax Medical Center Family Medicine Residency Program in Daytona Beach, FL. He has been painting since medical school and has had art shows in Venice, California and Amelia Island, Florida.

A SEA OF WINTER GREEN
Joshua Davis
Class of 2025

The Girl in Bed 3

Sarah Smith, DO

Still haunts me.

Maybe because then, she
was the same age as me.

Maybe because when
I lifted the sheet,

I watched her hair
cascade over the edge

and remember her lips,
the shade of lavender.

And snow-white skin,
like crystalline.

Maybe because she was gone
before we even met.

And a paramedic observed,
"We don't usually see 'em this young."

And I thought, couldn't he at least utter a
"Life's not fair?"

CAUGHT RED-HANDED

Maggie Li

Try your best to take a history. I'll meet you there in a few minutes, my resident says. No problem. I'll bet I can think of a joke just cheesier than the hospital caf's pizza that'll get a chuckle – something to appease my gnawing need to make a patient feel a little more at ease. By the way, I'm now good acquaintances with the PMHx, FMHx, and SocHx, and if there's time, sure, I'll blunder my way through an MSK exam, no problem.

Except within a minute of walking into the room of this "pelvic fracture direct admit" I realize: there is a problem. She rouses slowly at my calling but doesn't seem to recall at all what brought her in, what hurts, her name, or where she is.

Okay, what about this: I try again, in Mandarin.

She gasps softly. Her eyes become crescents as she beams in recognition of her native tongue. There's hope on the horizon! But that hope is quickly shrouded as she nods in answer to my open questions. She gestures vaguely to the wall, the ceiling. Yet her gaze steadily returns to my face and that smile of recognition does not fade. Still, so much for building rapport if I don't understand what she's telling me, and if she ends up feeling ignored. That would be a problem.

I've watched my preceptor countless times reach out and rest his hand on a patient's shoulder. I think it's his way of saying, *I'm for you, we're on the same team*. And then he'd say, let's hear your questions. There's something so collaborative about that.

But here's the problem: I am not my preceptor. A decade of experience separates us – plus, my hands and brain are wholly untrained. My surgical skillset includes the following: retracting, occasionally impactor-whacking (yes, I've felt the elastic recoil of the bone). I can also clumsily staple with both hands, cut sutures, and help push the patient bed almost home.

THESE RITUALS WE PLAY
Matt Johnson

As part of our internal medicine rotation we were tasked with reflecting on our experience caring for patients on the wards. Many students chose to write wonderful stories about their experiences through the literary arts, but words don't come as easy for me. I prefer the visual arts - something that can be altered by interpretation and isn't so rigid in its meaning. Here I depict the morning ritual my patient and I shared at the end of my prerounds. Our daily handshake, a simple enough thing, is something rarely encountered in healthcare these days. In the wake of a global pandemic a simple connection through the shaking of two hands can be refreshing. When one is bold enough, to embrace another commands respect, connectivity, and honor (when aided by a generous lathering of hand sanitizer). I enjoy the branch-like line work in this piece and the communication between both forms. There is a dueling tension over who is lifting the other up throughout this piece that evolves with my mood and on how I orient the piece horizontally or vertically.

Hear me out, unlike my preceptor, I cannot offer her the partnership or gift of a new knee or new hip. I cannot offer her a new lease on life. If anything, her x-rays will be offered as a teaching point tonight: my resident has promised to let me figure out the type of pelvic fracture and try my hand at summoning a management plan.

That's my problem. I stand in this room with 2 weeks of insight on the wonders that ortho can do, but I can't even do what was asked of me: a simple history. But hey, maybe now is the time to try to emulate the greats.

So, I brush her hair out of her face, place my hand on her shoulder and ask, *are you comfortable – do you have any questions right now?* Eyes fixed, blank stare. I try again. *I'm here. You're safe.* Her smile widens. *What can I do to help?*

> ***"I offer my hand and she cradles it so tightly and with such conviction."***

She stirs. Slowly, she reveals two red wool-covered hands. The same kind of fingerless gloves my grandfather made the winter I immigrated here. She holds them out to me and continues to reach. I offer my hand and she cradles it so tightly and with such conviction. I'm embarrassed, but she doesn't seem to mind at all the "Tile vs. Young-Burgess Classification" I've scrawled on my palm.

She wanders into sleep with my hand in hers and I think of the rule at Disneyworld, where the employees who dress up as Disney characters are instructed to not be the first to let go of a hug that a child initiates because you never know how much the kiddo might've needed it. Now, I'm no Disney Princess, but I think: how painful it must be to sustain a pelvic fracture so severe it landed her here, a decent drive away from her family's place. How lonely it must be to have an inability to communicate and to find it increasingly difficult to make sense of the world she's in. So, I hold on.

My resident returns. I'm caught red-handed. Literally. I have no history. She did gesture to her name written on the wall and nodded when I asked if she was in her 80s, but that's all. No further history. No worries, my resident replies. *Will you translate?* I oblige. *Can you wiggle your toes?* She can. *Does this hurt?* She moans.

The resident puts the family on the phone. We gather our history. 85-year-old with severe dementia, unwitnessed fall, likely several hours down before she was found. I am gladder than ever that I did not hesitate to hold her and tell her she's safe. My resident beautifully explains risks, benefits, alternatives, and gains SDM consent for her surgery. I broadly translate what's taking place into the patient's ear, unclear how much she really understands. But if there's a chance this means she won't be completely surprised when she's wheeled away for surgery in a day, I'll take it.

One last hand on her shoulder, then I set her gloved hands back beneath her blankets. *We'll take good care of you. You're safe.* Gloved hands re-emerge as she waves, and we walk away. There is both a heaviness and a joy inside.

Tonight, I couldn't take a history. But I learned I don't need an FRCSC to participate in a patient's healing. And maybe surgery is more than the cuts we make or percutaneous screws we use.

Tonight, it looks like speaking the words of this patient's motherland and holding her outstretched, red-gloved hands. Will I do that? *Absolutely, no problem.*

Maggie Li is a fourth-year medical student at the University of Toronto. She loves terrible puns, beautiful stories, creating music, embroidery, and has yet to lose a game of Anomia (which her friends and family now facetiously refer to as 'Anemia').

Sunrise Soon

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

I wrote myself
a note
reminding me
to write a poem.

A lifetime of reading
scrawled prescriptions
did not prepare me
for this.

A lifetime of incipient
death
prepared me well for this,
and yet.

I tapped out a title
as daybreak
touched my window
and wrote:

Poem about staying up all night not being able to sleep with racing thoughts about Uncle Jim's death and the inevitability of having to process my dad's death someday unless I die first—worse, and either way there won't be a cryptic message from him saying to call when I can—and seeing the "sunrise soon" notification pop up in the computer system tray at 6:22 am while feeling like the sun won't actually come up the same way again now that the darkness has begun to descend.

As in all things
I only realized
the note was the poem
after the fact.

DAYTONA DAYS
Nick Thomas
Class of 2024

ORCHID TREE—VIETNAM
Dan Van Durme, MD
Senior Associate Dean for Clinical and Community Affairs

The Transfiguration

Janet Cincotta, MD

Impotent: how you feel when a patient under your care is dying, and medical science has nothing more to offer. When you've tried everything, and nothing has worked. You feel like a failure, so "not God," as is sometimes still expected of physicians. It haunts you, especially when the patient is a child, or someone you know, or your own parent.

My father, for example, died a perfectly modern medical death, and there was nothing I could do about it. Post-operative complications of failed vascular surgery compounded by chronic lung disease took him down even though he was surrounded by life support paraphernalia of every description. Even though he was attended 24/7 by bright, dedicated doctors and nurses throughout the entire ordeal.

In the end, he died alone in the Intensive Care Unit because people were too busy to notice when he took his last breath. If the alarms hadn't called them to attention, no one would have known. He died alone while I frittered the moment away with my mother in the visitors' lounge where we'd gone for a cup of coffee. No one came to get us. No one drew us to his bedside in time to say one last good-bye. And by the time we were summoned, it was too late.

The truth is that doctors come to expect this kind of thing. Family members do not. Right from the start medical students are warned about it, and then they are trained to deal with it. For me, the seeds of indoctrination were sown on the very first day of medical school when the dean of the College of Medicine stepped up to the podium, and one hundred eager students, terraced like rice paddies on a hillside, snapped to attention.

He congratulated us on our academic achievement and our noble aspirations. He spoke about tradition and honor. He went on and on about dedication, self-sacrifice, excellence, courage, and the ethics of exhausting work. But the bottom line was, "Do no harm." And in the next breath he declared in no uncertain terms, "The day will come when a patient under your care will suffer or die because of something you did, or something you failed to do, and it will be your fault. You will have no one to blame but yourself for having been careless or hurried or ignorant or, God forbid, arrogant or indifferent. You will bear the burden of guilt for the rest of your life. You will never get over it."

He surveyed the blank expressions arrayed in front of him, and then he went on. "If for a moment you doubt what I am saying, you are invited right here and now to gather up your belongings and leave. Go. Depart."

He paused, stepped away from the microphone, and waited. He scanned our fresh young faces row by row as if he knew exactly who among us would be unable to bear it when—not if, but when—a patient died under our care. I remember locking eyes with the man as if he were able to judge strength of character and depth of devotion by the size of one's pupils. He was waiting for the fainthearted among us stand up so everyone could get a good look at what it meant to be a coward. He might just as well have asked those of us who had dropped acid over the weekend or those of us who preferred unprotected sex to stand up in front of everyone so we could hang our heads in shame as we shuffled out the door. But no one left. A few of us shifted nervously in our seats, but who would admit it?

When he stepped back up to the microphone, he sounded incredulous. "No one?" He paused. "Then God help you." And with that he doffed his glasses, picked up his notes, and left.

One hundred fledgling medical students responded with stunned silence. Then someone in the back row chuckled, as if to say, "What the hell was that?"

That, we would learn, was the power of prophecy. It was inevitable that patients—even children who were critically ill or injured—would die under our care, in the emergency room or on the operating table or in the intensive care unit. Despite our best efforts, patients would slip away from us. We were warned to expect it, and we were taught how to deal with it.

In medical school, when a patient died, we learned to tell ourselves there was nothing we could have done to prevent it. We were not to blame. It was the incubus of exhaustion, the sophistry of the gods at work. Put it out of your mind, we were told. Better yet, pretend it never happened. We were told to move on. We had work to do. Hope to instill. Trust to inspire. Destiny to ordain.

For four years the men of medicine took hammer and chisel to us until compassion fell away like dross—a smoldering pile of words that longed to be spoken, of hands that begged to be held, of tears that never fell. And out of it we emerged transfigured—tireless, dispassionate, infallible. Or so we were led to believe.

Over the years, though, experience taught me otherwise. When I knew a patient was dying, I learned to stay at the bedside. To check for a pulse myself. To place my stethoscope on the patient's chest and listen for a heartbeat even though

the monitors had already gone silent. I met with the patient's family and explained what had happened. I did my best to answer their questions.

I didn't make up excuses. I didn't turn the situation over to the nurses, or the hospital chaplain, or to someone from social services. I finished the job. I believed in the healing power of the physician's presence and the importance of her touch, and I still do. We all did. We respected the roles of ritual and expectation in healing, and we honored the importance of compassion and human connection in patient care. Of course, this was in the day before the exaltation of the ten-minute office visit. Back when we still made eye contact with patients. When we enjoyed a holistic relationship with them, a trusting kinship that helped them heal. Even when healing was beyond our grasp, we stayed with our patients to provide support, comfort, and hope.

Today's overwhelmed health care provider may suggest this is what we have nurses, social workers, psychologists, pastors, and family and friends for. But by disengaging herself from the patient's psychological, emotional, and spiritual life, the physician sacrifices her connection with the patient, and with it, she surrenders her calling. Her passion. Her sacred duty.

Looking back, I realize that to deny the truth is to ignore a festering wound, a disfiguring blemish on the snow-white complexion of the soul. You can slap a bandage over it so it doesn't show, but still, you know it's there. The truth is that guilt aches and throbs even out of sight. It is as contagious as fear, as pernicious as anger, as deadly as pride. And it never heals.

I was twenty-three-years old when I started medical school. I practiced Family Medicine for over thirty years. It took me that long to acknowledge the truth. You can put fear and doubt behind you. You can move on to other things, but when a doctor attends a patient's death, she bears the loss forever in her heart.

Dr. Cincotta is a published author and physician with over thirty years of experience in family medicine. She is a contributor to Empower—Women's Stories of Breakthrough, Discovery and Triumph, *and her short stories have appeared in* The Storyteller Magazine, US Catholic, Central PA Magazine, *and the 2016 Writers Digest anthology,* Show Me Your Shorts.

WITH EVERY STEP

Grant Banfill and Jeri Reisman
University of Florida College of Medicine