

# Becoming a Doctor at the University of Minnesota: An Anthology of Medical Student Stories



# **BECOMING A DOCTOR AT THE UNIVERSITY OF MINNESOTA: AN ANTHOLOGY OF MEDICAL STUDENT STORIES**

AUTHORED AND EDITED BY UNIVERSITY OF MINNESOTA MEDICAL  
SCHOOL STUDENTS

Minneapolis

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Spring in the Air by Jessica Flakne

# DEDICATION

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In remembrance of Matt, Dylan, Chris, and Ryan

Our community misses you. Your stories are not forgotten.

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## **Student Editorial Board**

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Ben Trappey, MD, Associate Director, University of Minnesota Medical School's Center for the Art of Medicine; Reflective Writing Thread Co-Lead, Becoming a Doctor

# FOREWORD

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This collection marks the first anthology of essays and poems written by the medical students at the University of Minnesota Medical School on their journeys to becoming doctors. Most of the entries were written as part of a required medical school course, “Becoming a Doctor”. I am moved by the notion that reflecting and then capturing those reflections in prose or poetry is an integral part of what it means to “become a doctor” at the University of Minnesota.

I am even more moved by the stories themselves. I have had the privilege to read these essays over the past three years, and always come away with the same conclusions: 1) our students are impressive ethnographers—they are committed to observing to learn to that they may work to improve the human condition; 2) we are all fallible—how we deal with that fallibility makes all the difference; and 3) relationships are the key to healing—with our patients, each other, and ultimately, ourselves.

I am certain the poems and stories you are about to read will resonate in different ways with each of you. They may awaken feelings of joy, sorrow, or bitter sweetness. You might conjure images of a relative, friend, or yourself in the stories they tell. They may well evoke laughter, tears, or both. In each entry is an opportunity to read, listen, and grow. I am already excited for all of you for what lies ahead in these pages, and forever grateful to those who contributed. As I read these pages, I can only be optimistic for the future of medicine, and comforted in the knowledge that you will all be there to care for me in the years ahead.

With profound gratitude,

A handwritten signature in dark ink, appearing to read "Bob", with a stylized, cursive script.

Bob Englander, MD

Associate Dean for Undergraduate Medical Education

# PREFACE

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What does it mean to become a physician?

This was the question that was at the front of our minds as we began to design the Becoming a Doctor course for the University of Minnesota Medical School in 2017. Led by Dr. Anne Pereira, Assistant Dean for Curriculum, major changes in the structure of the medical school's clinical curriculum had recently been made that created four weeks of "intersession" during students' third and fourth year of medical school. These weeks were meant to complement students' experiences in the clinical environment, helping to ensure they were equipped for success as residents and practicing clinicians.

As we began to design this course, however, we discovered that answering this question was challenging and complex. What did our students need? How do the answers to these questions change and evolve over time?

After many discussions with faculty, students, and medical school leaders, the answer began to come into focus. Our students didn't need more content about basic or clinical science – there is already more of those things in the curriculum than can be effectively learned or retained. Instead, our students needed time to come together and make sense of the experiences they were having during their journey to becoming a physician. They needed to ask questions of themselves and one another, seeking answers while also realizing that often, there are no answers.

They needed time and space to reflect on questions such as:

"What does it mean for me to become a physician?"

"How can I use my voice as a physician to advocate for change?"

"What do I do when my patients die?"

We realized the most important gift we could give our students was an experience that held space to ask and try to answer these questions, while also intentionally building community. While we initially focused on the content that could be delivered during these weeks, we quickly pivoted to considering how we could hold space for making meaning. Holding space for this important work, however, meant ensuring that students were encouraged, equipped, and empowered to engage in reflection about who they are, who they are becoming, and how they can be the healers, teachers, researchers, and advocates that the world so desperately needs. This also meant focusing on being and staying whole and well in the chaos of modern medicine.

Once this mission became clear, we recognized that the only meaningful way to assess our new course – focused on professional identity formation, reflective practice, and community building – was through reflection. Thus, students are asked after each week of our course to compose a written reflection about their journey toward

becoming a physician. These reflections, some of which are contained in this anthology, represent our student's journeys toward becoming physicians at the University of Minnesota Medical School. With our gratitude for the efforts of the authors, the student editorial board capably led by our editor in chief Lizzy Kim, and advisory support from faculty and trainees, including through the Center for the Art of Medicine, we are honored to share these voices and stories in the anthology.

They are honest, optimistic, realistic, woeful, wondering, believing, doubting, persevering, joyful, and grieving. Said simply, they are real.

They are complex and beautiful – and deeply important. Just like the practice of medicine.

We are deeply grateful and humbled to walk this journey with you, our students, and we welcome you to the practice of medicine. This is a broken, hurting world; yet, you will make a very real difference in it.

Andrew P.J. Olson, MD

Founding Director, Becoming a Doctor Course

Johannah M. Scheurer, MD

Founding Assistant Director, Becoming a Doctor Course

# INTRODUCTION

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At the white coat ceremony that marked our entrance into the medical community, we extended our arms backwards as our faculty advisors assisted us in donning white coats for the first time. We walked across a stage and received a black, rectangular box. Inside was a stethoscope: a tool for listening.

As we began to build our physical exam skills, our stethoscopes introduced us to the comforting consistency of the lub-dub from closing heart valves and the mysterious pitch of grumbles of bowel peristalsis. We also learned about listening for signs of the health of the lungs. Were the lung sounds clear bilaterally? Any crackles or wheezes? Was the vowel “e” or “a” winning a battle within the lung parenchyma, and how many times is appropriate to ask someone to whisper 99 before the interaction becomes uncomfortably awkward? In addition to the sounds our stethoscopes revealed, we also began to encounter the beauty of listening to patient stories. At times we sat in silence or held someone’s hand, while other times we shared in laughter or shed a few tears. We transitioned from the lecture hall to rotations, figuratively taking in a big, deep breath, as we tried to hold onto as much new information as possible in our first experiences in clinics, on hospital floors, and in operating rooms. In our symbolic inspiration we started discovering our identities not only as medical students but also as future physicians.

In March of 2020, our inspiration hit a pause. Our ability to use our stethoscopes or to listen to patient stories was temporarily held due to the COVID-19 pandemic. With a mix of fear, sadness, and intellectual curiosity, we heard of ways a novel virus was affecting the lungs of numerous individuals. We quickly adapted as we engaged in virtual curriculum opportunities and demonstrated creativity as we found ways to help our community while away from the clinical learning environment. Unfortunately, a few months later, our breath was again paused as our city watched George Floyd’s death following pleas of not being able to breathe.

Amidst the challenges of the past year, we will exhale. We have returned to clinical rotations where stethoscopes around our necks are now accompanied by masks on our faces. Beyond heart, lung, and bowel sounds, it is wonderful to again listen to patient stories – although we recognize conversations are often with louder voices and less interpretable facial expressions. We are additionally grateful for the role of Becoming a Doctor courses in our figurative exhalation process. In exhalation, the diaphragm relaxes, lungs recoil, and carbon dioxide is released. Becoming a Doctor courses have symbolically been times to breathe out as we experience the value of intentionally slowing down and taking time to reflect. These courses have created space for us to articulate frustrations and describe our hopes for positive change in the future. With this foundation, we look forward to pressing on in lifelong learning as we, with humility, strive to best serve our patients.

And so, we invite you to listen to our collective respiratory cycle: to moments of inspiration, pause, and exhalation. It is with deep gratitude we thank the incredible patients and the courageous, gifted authors who have contributed

to this anthology as well as the thoughtful leaders, wise mentors, compassionate physicians, and faithful support networks who have helped us in becoming doctors at the University of Minnesota.

Elizabeth Kim

On behalf of the Student Editorial Board

# WHY STORIES MATTER

---

Humans are the storytelling animal.<sup>12</sup> It is our stories that define us, connect us, comfort us, and (if we let them) heal us. They are how our ancestors transmitted information from person to person and from generation to generation. Stories are how we learn from the past and prepare for the future.<sup>3</sup>

For many years, stories were also at the heart of the practice of medicine. Hippocrates understood that his effectiveness as a healer and a teacher was tied to his ability to tell the stories of his patients and their experiences.<sup>4</sup> For centuries, medical knowledge (limited though it was) was transmitted primarily through case reports—detailed stories about an individual patient, their signs, their symptoms and how they did or didn’t respond to treatment.<sup>5</sup>

But as medicine moved from reliance on anecdotes to empirical evidence, stories fell out of favor. With the development of pathologic anatomy and germ theories in the 18th and 19th centuries, respectively, disease began to be seen as separable from the patient’s body. Disease was the result of external forces to be understood rather than a unique experience afflicting an individual.<sup>6</sup> And with the rise of the randomized control trial and evidence based medicine in the 20th century, we as a profession not only ceased to rely on storytelling but to reject it completely. “Science has stood as the opposite of storytelling, seeking to replace old wives tales with provable generalizations.”<sup>7</sup>

But at the beginning of the 21st century, some in medicine began to circle back to the recognition that our humanity and the stories that are so deeply entwined in it are impossible to excise from the work that we do in medicine.<sup>4</sup> “Over the course of our careers, we accumulate hundreds, thousands of stories...myths and legends that circulate the wards as slyly as MRSA”.<sup>8</sup>

To deny ourselves the opportunity to tell the stories of our lives in medicine is to deny ourselves a powerful tool for healing. There is a large body of evidence that crafting the story of an emotional or traumatic experience can have surprisingly restorative effects.

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Stories also have a powerful ability to connect us. Recent research shows that the sharing of stories creates a unique bond between the storyteller and their audience. Listening to stories results in a “neural coupling” in which the listener’s brain is engaged in a way that mimics the brain activity of the storyteller.<sup>9</sup> This connection between storyteller and their audience is further amplified when strong emotions are being conveyed.<sup>10</sup> Similarly, there is a deep body of literature describing the rich cognitive and emotional reactions that are triggered when engaging in a story.<sup>1112</sup>

So, we hope that the contents of this anthology will live up to all of the promise that stories hold. We hope that they will be an intimate record of the thoughts and feelings of students whose medical education was uniquely impacted by the COVID-19 pandemic and the civil unrest that rocked the Twin Cities in the wake of George Floyd’s murder. We hope that they will provide readers with a sense of connection as captivating as it is authentic. And finally, we hope that they will remind you that narrative is still the beating heart of medicine, tying us deeply to our patients, our colleagues, and who we are as human beings.

Ben Trappey, MD, Maren E. Olson, MD, MPH, MEd, Anthony Williams, MD, MS  
Associate Directors, University of Minnesota Medical School’s Center for the Art of Medicine

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# INSPIRATION



# REFLECTION

Paulina Marell

---

I'd like to tell you about three people.

The first person, a woman approaching old age, came to talk to our class in the fall. We were studying genetic disorders and mutations; hers was BRCA1. She had had ovarian cancer not once, not twice, but three times. And breast cancer too, to top it off. She was candid and brash. She told us that the worst part was losing her hair over and over. She told us, too, about the privilege of being able to give information to her daughters to allow them to make choices that would prevent the repetition of her illnesses in their lives. She spent the last ten minutes of the lecture talking about her grandchildren.

The second was a man with a diagnosis of ALS. I was reminded that he spoke to us during our first year neuroscience course; my recollection of the first two years of medical school is already starting to blur. What I can remember clearly is how he looked sitting in a wheelchair and puffing on what looked like a large bendy straw positioned near his face, each breath otherwise requiring a full body twisting motion. Despite this, he spent the effort to speak, jumping in when his wife or son, who sat on either side of him, didn't quite get things right. At the end of the talk, he asked us to remember that patients are never merely patients but also brothers, sons, and fathers. As he said the word "father," he hung his head and began to sob, quietly yet terrifyingly audibly in the expansive silence of the lecture hall.

The third was a woman who, due to an autoimmune disorder, had been forced to have multiple kidney transplants. This was during the second year of medical school, and we were studying nephrology. She talked to us about facing a life-altering illness while young, in college, and trying to live a normal life. She told us about the metal taste of uremia. She had, quite possibly, the most upbeat and joyous attitude of anyone I've ever met. Her demeanor was so striking to our class that someone finally raised their hand and asked how she could be so happy in the face of unrelenting disease. She stated simply that she was happy because she had come downstairs that morning to find that her husband had left flowers on the table for no particular reason. So, of course, she was happy.

We are often asked to reflect on our experiences in medicine. And it's no exaggeration to state that each day on our clinical rotations, days filled with patient care, could each be the subject of their own essays. And yet, when I sit down at the keyboard and let my mind wander, it's these patients that I think about: folks who came to talk to us during the first two years of medical school.

They came to us when we were just on the cusp of our medical careers, when everything was shiny and new, and they came as surprising reprieves from days that were otherwise filled with lectures and case studies. I was just beginning to come to terms with the idea that I was in medical school, that I would one day be a doctor. And the fact that people might sit in front of me and my classmates and tell us about their medical problems was frightening

and thrilling and somewhat hard to believe. These patients, these people, entered my life as I reconstructed and reconfigured my sense of self, and, as such, I worked them into the fabric of this new me somewhere deep and thickly intertwined. They are the seminal prototypes for all the similar patients I've gone on to meet. When I think of how overwhelmingly impactful changes in the chemical structure of our DNA can be, I think of the first woman and her children and grandchildren. When I think of uremia, I think of the other woman that I've shared with you, and metallic taste is the easiest symptom for me to remember. When I think of ALS, I think of that man, even though I've since met others with his same disease. And when I think of raw suffering, I think of him, too. Their faces have become dictionary definitions for me.

I've thought many times about what it would be like to dissect your body's malfunction in front of a room full of people. It makes my palms sweat. Would I set aside my closure, my comfort, my dignity to prioritize the education of a stranger? To be frank, I probably wouldn't. Yet the immenseness of the gratitude I feel that a handful of people did just that is overwhelming. These patients, these people, did not just talk about their diseases. They shared stories of themselves that were cohesive, analytical, and probing. There were whole sections of their speeches that I encoded with perfect recall as I sat and listened in rapt wonder. Their stories were personally formative and professionally illuminating.

I've met many people who were good at reflecting and examining: classmates, whose parallel journeys along mine have grounded and informed me; physicians, whose mountains of experience have shaped who I hope to become; writers both in medicine and outside it who have left me with words to express what I couldn't previously say. But of course, I've left the best for last: the people who came to speak with us during the first two years of medical school, people who somehow digested years of intense personal trial into stories that function as tools in my back pocket. They are the masters of reflection and it's been a privilege to learn from them.

# PAGING 612-818-8067

Lauren Summers

---

Paging 612-818-8067... Paging 612-818-8067...

“6...1...2...7...2...5..”

“We’re sorry. We are unable to complete your call as dialed. Please check the number and dial again, or call your operator to help you.”

*Maybe I need to dial 8 for an outside line?*

“8...6...1...2...7...2...”

“We’re sorry. We are unable to complete your—”

Click.

*Shoot, 8 was my last hospital. Ummm, 9. I think it’s just 9.*

“9...6...1...2...7...2...”

“We’re sorry. We are unable—”

Click.

*But it’s definitely 9.*

“9...6...1...2...7...2”

“We’re sorry—”

Click.

*I have literally hundreds of thousands of dollars worth of education. I should not be bested by a telephone.*

RING-RING!

“Hello. Lauren? It’s Dr. Serposs. I thought you were gonna call into my first appointment?”

“Yeah, yes. My apologies. I was having some difficulties with the phone—”

“Did you try dialling 9 for an outside line?”

“...”

Thunk.

That was the first, though most innocuous, time today that I was faced with an overwhelming urge to thunk my head against the desk in defeat. But I was saved from the headache by a mysterious beeping noise! My...pager? Someone was actually paging ME? I didn’t know why anyone would page me, but I did know that to answer a page at the VA you needed to call the number displayed on the screen. Which meant I was going to have to go toe to toe with the telephone again.

I did not anticipate that telephone operation would be the most pressing and challenging skill that I would learn

during my first week of VALUE. I knew that I would be developing my “advanced clinical skills,” but I was thinking more along the lines of point of care ultrasound, EKG interpretation, and electrolyte replacement – certainly not operating a telephone. And yet, as I reflect on my tangles with the telephone, I can acknowledge it as a vitally important learning moment, beyond the obvious necessity of utilizing it as a means of communication. Asking for help requires humility, and I most definitely needed to ask for help. The battle to subdue my shame at failing to perform such a basic task so that I could humbly ask someone for help was exceedingly difficult.

As a medical student, our full time job is to learn massive amounts of information. Subsequently, we get really good at knowing things. There is an endless parade of exams testing how much we know and threatening failure if we don’t know enough. Then we enter our third year clerkships, and we don’t know anything – how to find the bathroom, how to enter orders, how to tell CPRS I am not now, nor have I ever been, in the 4<sup>th</sup> floor pharmacy. Despite all this mental conditioning, we must learn to accept how much we don’t know and learn to humbly ask for help. That is the true “advanced clinical skill” I developed.

But it was time to put introspection aside and put that shiny new clinical skill to use – I had a page to answer! I wrangled my pride and sheepishly poked my head into Dr. Serpos’s office to ask for help. Armed with his advice, my second attempt at the telephone had minimal misdials, and I was able to reach the emergency department. One of the patients I follow longitudinally presented to the ED with cellulitis. The staff physician readily agreed to allow me to be involved with the patient’s care.

I made my way down to the ED, mentally reviewing what I knew about cellulitis. The staff physician took me back to interview and examine the patient. When we got back to the work station, the questions started flowing: “Are they septic? By SIRS or by SOFA? NEWS2? Are you going to send them up or out? To what level of care? Obs? Tele?” The unfamiliar acronyms and nicknames were overwhelming. While the recent Becoming a Doctor Week I session on Jargon recommended that we put ourselves in the patient’s shoes, I did not plan on taking that advice quite so literally. I must confess I found it quite uncomfortable. I stumbled over questions that I should have known the answer to: “Obs? I don’t, I don’t know, What’s that?...Oh...” At least I had a fundamental understanding of what those things were, even if I didn’t recognize the jargon. But our patients do not have that medical knowledge to fall back on. When healthcare providers start going on about lactate levels, bicarb, and their sulfonylurea, patients feel every bit of the confusion I felt, and then some. Just as I needed my staff physician to fill in my knowledge gaps, so too do my patients need me to take care to slow down, be deliberate in my word choice, and check in about how much they understand.

I accompanied the patient up to the medicine unit, where I performed the patient’s admission history and physical – my first ever admission. I will follow and round on the patient throughout their hospital course, making sure to take the time to use patient centered language and answer their questions as we go. They’ve taught me a great deal in just one day. I can only imagine what they’ll teach me tomorrow and how much help I’ll need along the way. But for right now, I’ve got another phone call to make.

# LACING UP MY DANCING SHOES

Alycia Chmielewski

---

“Don’t let medicine change who you are.” It was almost eerie how those words were becoming so common during feedback sessions. “Don’t stop being yourself,” cautioned my senior resident. I laughed initially at these warnings, and then quickly probed preceptors and residents further as to what preceded these warnings. I knew who I was and, considering how stubborn I am, I could never imagine changing my quirks. What was it about the process of completing medical school and residency that warranted such warnings? Any medical student is well aware of the picture that residency painted: tired, worn-down people whose names were preceded by “Dr.” I had to wonder why my senior residents and attendings continued to comment on my personality as if I too would soon be broken and molded into someone new.

I can’t help but think of my first patient I followed during my medicine rotation. She was not much older than me and had already garnered significant attention by other residents when they read through her labs. Her physical exam and lab findings pointed toward a new diagnosis of autoimmune hemolytic anemia. The whites of her eyes were instead neon yellow and the results of her hemoglobin were accompanied by bright red exclamation points: 3.1. “I wonder if that’s one for the record board?” a resident chimed. For me, I shook my head as I knew she was more than a number chalked up on a resident lounge whiteboard of vague yet extreme lab values. Up until the day she was admitted, she had pulled herself out of bed to try and chase after her kids, even when her fatigue was unbearable. I couldn’t help but be in awe of the fact that while others complained of fatigue when only slightly anemic, she had been mustering up any strength to care for her family prior to admission. Over the next few days, I had cooed over the many pictures that she would show me of her four kids, talked to her mom over speakerphone, and discussed in length our favorite cafeteria meals. Each morning, the resident and I would run through the results of the morning labs with our patient. She would vent frustration of how slowly her hemoglobin was ticking up. Over the next few days, we chatted about her family, work, or favorite hospital meals as she remained tied to her IV pole for required transfusions. On day six, with a smile across their face, my resident announced that the patient’s hemoglobin was 7.0. I couldn’t help but throw my hands up and boogie, which was met with laughs from all in the room. This result was a small victory but one that warranted some dance moves, especially for a patient I had quickly grown fond of. It would continue to be a joke on our team as to what results would warrant a dance from me, which I was always happy to provide.

Unfortunately, not every patient interaction has a happy ending. During the concluding weeks of my medicine rotation, I was seeing an elderly patient during his fourth admission in six weeks. His recurrent pleural effusions were thought to be a product of persistent pneumonia, but further workup during a previous admission ultimately revealed cancer. His breathing issues were further complicated by his progressive dementia as he was most distressed with his breathing during confused episodes, warranting an emergency department visit. During this admission, our team had to deliver the news that no further options were recommended except for hospice care. Before we

entered the room, I was fearful that I would not be able to control my emotions and match the somberness and strength that I assumed all doctors showed. To my surprise, I watched as my resident's voice cracked while sharing the news with the patient and his wife. Being an emotional person myself, I quickly joined in on sharing tears as everyone in the room passed around tissues. This somber moment was broken by the familiar soft smile of our patient, as he held his wife's hand and said "let's go home." When debriefing with my team following the conversation, I felt reassured in my ability to work in medicine as my resident and attending physician shared stories of crying with other patients. Medicine allows one to take part in many positive conversations. I, however, was grateful to take part in the difficult ones as well.

I try to imagine myself after residency, having my own practice and patients. Will I still be eager to share great test results with my patients? Will I want to take a second to boogie with them? Will I be vulnerable and shed tears with them and their families? I think about the physicians I have worked with thus far. Have they changed since being third-year medical students, caught in between who they were before their training and who they must become to survive it? I hope that they haven't changed much since their time as medical students and still have their own quirks that they share with patients. I thank my residents and preceptors for recognizing my quirks and for reminding me to be grateful for these traits. I don't plan on letting medicine change who I am and, frankly, I have no intentions of losing my dance moves anytime soon.

# MORE THAN 308

Namrata Damle

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*50 year-old male with daily aspirin use presenting with melena and hematochezia and abdominal pain.*

I met Shane after he arrived in the Emergency Department with his wife to be seen for having tarry stools which he had tried to “tough out”. He was perched on the corner of his Emergency Department bed and was craning his neck to sneak a peek at the football game on the TV when I entered the room. The instant he saw me, he tried to make me feel welcome in his tiny corner of the Emergency Department. He told me how he had tried to “soldier through it ” the abdominal pain he experienced over the last whole day prior to coming in. Shane mentioned he had not seen a doctor in nearly 30 years, which greatly befuddled me. While he mentioned his lack of previous hospitalizations and his general good health, I privately wondered if the pandemic played a role in his new bleeding and abdominal pain. I excused myself and compiled notes about Shane and tried to create a comprehensive narrative to share. When I reported back to my resident, I felt my brief summary had not done Shane justice when a team member referred to him as “the GI bleeder in 308”.

Watching residents fly through placing orders and placement requests, I realized the team was focused on efficiency viewing Shane’s case as a diagnosis rather than a complete person with a story. As the team’s furious typing continued, Shane slowly left their minds as the next patient was discussed and addressed. One of the residents saw my additional notes about Shane and told me “when you are a student you have the luxury of time so please keep learning as much about your patient as you can!”

When I visited Shane the following day, he told me about the furlough and eventual loss of his job due to the pandemic. After joining the Marines right after high school, Shane suffered a serious head injury on his second tour of duty. This made finding new work especially challenging for him even before the pandemic happened. Between his loss of his job, having four school age children, and concern for his wife’s safety as a healthcare worker, Shane had multiple sources of stress. He had occasionally experienced GI distress throughout the pandemic but kept quiet about it to avoid being seen as a burden. He instead managed the discomfort by drinking ginger ale.

Shane’s hospital stay grew longer when esophagogastroduodenoscopy failed to reveal ulcers or a clear source for his presumed upper GI bleed. This gave me the opportunity to learn more about Shane’s life and his values. Simply put, Shane was a gentle giant passionate about family, faith, freedom, and football. Day by day, I would talk to him about his diagnosis and troubles, and slowly added the details of Shane’s social history into my presentations. Each morning, I would tell Shane what I was sharing with the team, and as Shane got to know me better, he easily started to jump in and supply more information that he thought would be helpful. One day, while discussing his medication use at home, I discovered that Shane took nearly three times the charted aspirin dose of 81 mg. He stated “I don’t really have extra money to see a doctor too often and my dad started taking an aspirin a day when he

was my age, so I figured I'd do that too! Since I'm a big guy I figured why not take a little more." After uncovering these deeper concerns Shane had about his health, I used some motivational interviewing to encourage regular visits with a doctor and to get medical advice before self-medicating.

During medical training, we constantly learn to triage information and make decisions regarding what is most pertinent and informative for the current diagnosis and development of a treatment plan for the patient. In a patient's case like Shane's, focusing on his hemoglobin levels and consulting the GI team would have been the efficient route. However, as I gradually got to know him and presented him as a whole person, my resident team stopped referring to him as the "bleeder in 308". We all learned the names of his children and his wife, and made sure to congratulate him when the Packers won. After multiple transfusions and several days, Shane asked us to "level with him" about how he would fare after leaving the hospital. He wanted to know if he would be able to play football with his sons or give his youngest child piggy-back rides. As his frankness about his fears for his future health increased, Shane became more comfortable voicing his opinions about the progress of his care. By taking the time to learn more about Shane, we all became more invested in his care because we understood why he needed to get better.

Even after placing consults to GI, Surgery, and Interventional Radiology services, our team remained enthusiastic and active in Shane's care. As I became his ally, I personally felt much more confident advocating for Shane through my charting and discussions with specialists who appreciated and capitalized on the small details I provided them about Shane's personal or family history. We strove to ask care coordinators and social workers if there were any resources or things that Shane and his family could take advantage of. We were very invested and wanted to set Shane up for success after he left the hospital. We were truly determined to go the extra mile for him and his family because we understood what motivated Shane's recovery, and we supported the key cornerstone of his foundation for wanting to be healthy for his family and to be able to provide. Uncovering the root reason for his aspirin use through pursuing his story allowed us to set him up with appropriate outpatient follow-up thus demonstrating how narrative medicine actively improves patient care.

I know that all patients will not be as forthcoming and sharing as Shane was, and I know that I was lucky to have extra time to spend with him. However, I feel that using a narrative medicine approach to Shane's care benefitted not only my patient but also the entire healthcare team. At the end of his stay, Shane said he appreciated my transparency and my desire to share his full story with the team, and I learned more about his medical history and built a stronger relationship with him. While searching for social resources to offer Shane, I encountered many different specialties and providers including chaplains, care coordinators, and OT's who taught me about their roles in patient care. In addition to developing stronger professional relationships with other providers, I garnered knowledge about their resources which I will use to support my future patients. Modern medicine focuses on efficiency and evidence based care, but by taking even a small amount of time to learn about what makes a patient tick, we can foster a longer lasting trusting relationships with patients while making them feel heard. For patients like Shane, our practice of narrative medicine improves their outpatient follow-up and trust in the medical system. Incorporation of the powerful tool of narrative medicine would progress the field of medicine towards a more

holistic approach to patient care, and thus would cultivate an extra layer of compassion which would be felt by both patient and provider. This would go a long way towards forging connections which will last a lifetime.

# WITHDRAWAL

Jacob Reshetar

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“Go talk to this guy with alcohol withdrawal,” said my preceptor. “Sure thing,” I responded. Even if I was a bit unsure as to the workup of alcohol withdrawal, I was simply stoked to be on the emergency medicine service for an overnight shift. So, off I went, flying blind towards this patient’s room without so much as having seen his chart on a positively arctic evening in Minneapolis.

In retrospect, my naivete upon entering the room was cringe-worthy. I swung back the curtain, and before even introducing myself, said, “So, I’ve heard you’ve had a bit to drink.” A classic, novice bedside manner faux pax. Immediately, I was caught off-guard upon seeing the patient. He wasn’t all that much older than I was: tremulous, anxious-appearing — there was a sadness in his eyes. He was so clearly not in a good way that it completely deflated the jovial, well-intentioned ignorance that I approached him with. I knew I had to switch up the tone or else I’d never build a connection with him.

I pulled up a chair: “I’d like to hear your story,” I said, “it doesn’t need to be fancy, just in your own words. It’ll give me a chance to hear what’s been bothering you and how we can help. I’ll try my best not to interrupt, and I’ll chime in with questions if they’ll help me better understand how you’re feeling.”

“I don’t know man, it won’t be good, I can’t shut my mind off. My brain has been in high gear, I haven’t been able to sleep.” His gaze was fixed on his trembling hands. I wanted to reassure him: “Don’t worry how good it is, man. Just go for it.”

He sighed, paused, and glanced at me. “I’ve been an alcoholic for ten years.” There was another pause. “I drink anything brown. About a liter a day. My wife...” he paused. “She got sick of my shit. I’ve been a bad husband to her.”

I was shocked. I had known this guy for all of a single minute, and he was already disclosing extremely personal details about life to me — an MS2 who did not even have a reasonable workup for alcohol withdrawal. Still, I felt an earnest desire to hear this guy out. His pain was real. I could feel it, and it was up to me to be there with him, hear his story, and hopefully help him— I felt honored to be there in my own quiet way.

“Man, I can tell you’re hurting,” I said. “Emergency departments aren’t fun places to be in the first place. If you’re okay with it, I’d like to hear more about what brings you here tonight, and if there’s a reason why you brought up your wife just now.”

“Yeah, there is.” His gaze drifted back to his hands as he became tearful, his voice shaking, “She got sick of my shit, my drinking. I found out she was sleeping with another man three days ago. When I found out, I went home and

put a bottle of Oxycontin to my mouth, and I chased the pills with whatever I could find in the house. I hoped I wouldn't wake up." A tear ran down his cheek as he sniveled. "Somehow, I woke up, and for the past three days I haven't slept."

I was stunned, not just by his disclosure but by the immediacy of it all— how medicine and the lives of our patient's can impress upon us in such visceral and urgent ways.

It really felt like a moment where filling the air was the wrong move. In the expanse of that fleeting silence, I felt torn. A part of my mind was racing through the sterile scientific knowledge of differentials, toxidromes, labs, and medications. In my heart though, I felt this sting, a sense of tragedy for this guy. I thought, "This guy is really in it, he's going through hell right now, and there was a very real chance he could have died. He didn't die, thank God, and now, he's here chatting with me, even though I don't really know how to help him medically... But he's still here..."

I felt a sense of beauty and sadness in that moment with this guy who was a total stranger minutes before. I felt grateful to just be there with him, really. Grateful that he wasn't dead.

"Well man, first thing's first." I said as I shot him a warm grin and clapped him on the leg as he lay in his hospital bed. "I'm so glad I have the chance to meet you."

He looked up and smiled wearily, almost taken aback. "Thanks."

In the following minutes, we talked more about how much he's been drinking, where he was doing it, what he thought would be helpful for him, his social support system, and if he has felt like hurting himself or others since his suicide attempt. We both decided that getting some sleep would be a solid move since he was so exhausted and to use some benzodiazepines to reduce the risk of seizure as he came out of withdrawal.

I stopped by his room a few hours later while some of his family was at his bedside. Seeing him sleeping -finally having some peace- brought me some measure of happiness. I couldn't help him resolve all of the adversity in his life, but I got to be with him when he needed help. I played a humble part in resolving an urgent and dangerous health need he had at the time. "Sleep is a wonderful medicine in itself," I thought, somewhat ironically as I worked an overnight shift as a tired medical student.

What really stuck with me about that patient was not what we did for him medically or the dangerous status of his health, but rather how meaningful it felt for me to be there with him. People in healthcare often say that emergency physicians don't have longitudinal relationships with patients. And while that is true in a plain light, I would argue that emergency physicians experience their patients in extremely sensitive moments of vulnerability. In those moments, doctors have the opportunity to make an impression upon their patients that can be felt for a lifetime. The same can be said for patients unto physicians.

I don't think I'll ever forget that guy nor will he ever know how much it meant to me that I got to be there with

him. And that's OK. Perhaps that's the job. Perhaps that's medicine, or at least a large part of it. To just show up, to be there for people.

*"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." – Maya Angelou*

# PANCREATITIS PRISONER

Diana Rubio

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*'Pancreatitis of unspecified origin.'*

*'Pancreatitis from heavy alcohol use.'*

*'Pancreatitis due to obstruction.'*

It was my first week of internal medicine, and the theme for the day was pancreatitis. I digested information nestled in patient charts while sipping my morning coffee. As I rapidly read through EMRs, like a violinist playing staccato notes, I pieced together fragments of patient histories to better understand their medical problems and the lives they lived outside of the hospital walls. A '55-year-old male, incarcerated since 1990, admitted for acute onset nausea and abdominal pain' gave me pause. This patient had been locked out of society for as long as I have been alive. Curious to learn more about his story, I slowed my tempo to review his clinical encounters and hospital notes. While searching for an explanation, I noted the context of his incarceration was missing. Maybe I would find out on rounds.

I thought through physical exam findings specific to pancreatitis and important questions to ask before leaving the hospitalist workroom, stethoscope in hand, to interview the first patient of the morning.

I lightly knocked on the door before entering Mr. Jenkin's room. My outward appearance, unphased by the smell of sweat perfuming the room, the guards sitting at the bedside, and Mr. Jenkin's ankles shackled to the foot of the bed. I proceeded to introduce myself.

'Good morning, Mr. Jenkins, my name is Diana. I'm the medical student on your care team. How would you like to be addressed?'

Calmly laying in bed, he extended his hand to shake mine as he smiled and responded, 'Rob.'

We were off to a solid start. Rob shared the events leading up to his current hospitalization and allowed me to perform a thorough physical exam. I summarized our interview, my physical exam findings, and asked if he wanted to share additional information that he thought important for his care team to know. He had none and thanked me for my time.

I did not ask about his incarceration history. It did not feel right to ask him such an intimate question after our brief initial interaction. Maybe it would come up during tomorrow's rounds.

The next morning, I followed up with Rob and learned that he had not made much progress. The guards were stationed at the bedside while we discussed his belly pain and rated it on a scale from one to ten as I palpated each quadrant. Again, we did not broach the subject of life in jail.

Why did I feel like it was such an important topic to know? It would not change the management of his pancreatitis. But I also did not think it would change the way I would personally interact with Rob. Maybe by directly asking him, I would overstep my boundaries. Maybe asking about his story would attack his dignity or cause injury to his journey toward redemption.

By the third day, Rob and I had developed a morning routine. He knew what I was going to ask and what I was looking for in my physical exam. He proudly pointed out a slit in his gown to make it easier for me to get a good listen to his heart, he rolled to the side to help me auscultate his lungs, and he stretched his arms in my direction for me to check both radial pulses simultaneously. When I asked about his concerns, he said he was worried about staying for more than ten days because ‘they’ll put me back in the wall.’

Confused, I responded ‘the wall...what do you mean?’

‘They’ll put me back in maximum security...I’ve been in low security.’

We were in the same room and yet we were worlds apart. I did not know the difference between high and low security conditions or anything about jail life for that matter. *Finally*, this was my chance to ask Rob how he came to be incarcerated and get a glimpse of his life confined to a jail cell. Still, I did not ask. Instead, I tried to be reassuring, and said, ‘I’ll share your concern with the team. We’ll do our best to help you get back to your regular routine before then.’

According to a Prison Policy Initiative report, “2.3 million Americans are incarcerated in the US”<sup>1</sup> and “123,000 Minnesotans are behind bars or under criminal justice supervision.”<sup>2</sup> Rob was my first patient confined to life in jail, and he will not be the last. He reminded me about a segment of the population that is stripped of basic rights and ignored by greater society.

Things turned around for Rob on his fourth day in the hospital. He reported his pain well managed and appetite restored. I smiled wide, glad that Rob was feeling better, and that I witnessed his recovery as a part of his care team. After discussing his progress with the attending doctor, it seemed like he would be medically cleared for discharge the next day.

I was not in the hospital on the day of his discharge. I did not ask him his story. And even if I did, would he have trusted me enough to share his truth?

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# RED PATIENT ONE

Octavia Ruelas

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Mrs. Red was my very first patient. She was assigned to me as an eager MS3, chomping at the bit and more than elated to finally be out of the lecture hall.

*Red.*

Aesthetically, it was the color of her wig that always greeted me with a vibrant shine. Clinically, it was the color of the blood she was missing. She came to us (the inpatient medicine team) with a hemoglobin drop that was significant and unexplained. Her workup included an abdominal CT that showed spots peppering her liver.

“Severe anemia” became “occult malignancy.”

Suddenly, the red theme of anemia, hemoglobin, and her wig became the cold, ugly word we whispered around her when she was out of earshot: *cancer*.

Her vibrant wig was always the first thing I noticed when I walked into the room. Sometimes she had it on, smoothing out her edges nervously. Other times it was off, set down unceremoniously next to an empty food tray. The wig reminded me that this woman had a personality, a personhood outside of the hospital. The object was my only glimpse into who she was out there in the “real world.”

Mrs. Red was always warm to my touch. She never appeared pale to me, her dark skin hiding the occult blood loss from peering eyes. The pallor sometimes snuck out, though, in her downcast eyes and her too soft voice that was always sad and cautious.

Her husband often stood in the corner. A preacher and her guardian. He had this warrior angel vibe about him, like he was battling on his weary wife’s behalf. He was trying to be strong, tension held across his shoulders and chest. I think he thought that if he uncrossed his arms, he would fall apart, faith and all.

*Cold.*

That’s all the medicine team had to offer her. A cold unit of blood, a cold room, a cold diagnosis, and a medical student with cold hands.

I tried to make up for it later. I wished her a “happy birthday” on pre-rounds one morning after I noted she would be spending it with us. For a brief monumental flash, she smiled. It was a quick and shy thing that I knew I would never see from her again. It was beautiful, but it was too fast to share.

I hang on to that moment when I think of her, wishing that the smile had reached her eyes and that I could have seen it last a little longer. I can barely remember it now.

(Sometimes I wonder if I just imagined it).

As I continue through my third year of medical school, I often wonder how I have changed as a healthcare professional since meeting Mrs. Red. I wonder what patients see when they see me.

During one conversation, I remember Mrs. Red telling me she was not sure I was old enough to be in her room asking her questions. She was a little suspicious of the five-foot even, braces-wearing medical student asking very personal questions and coming in for a physical exam at 7am. She asked me how old I was in that direct, inoffensive way women of a certain age can ask you your age. I told her and she shook her head unbelievably. We chuckled about it.

Sometimes I worry that my somewhat young appearance and title of “Student” will make patients nervous. After thinking about my interactions with Mrs. Red, however, I realized that my petite build was not a barrier, but a segue. A point of human connection. I am small, yes, but I could sit down with her and listen to how the heating pad had shut off in the middle of the night, allowing her chronic flank pain to worsen. I might have been younger than she was expecting, but her husband remembered me when I ran into him on the wards a week later and caught up about why she had to be readmitted after my team’s discharge.

I have realized that there is no formula. No combination of brains or physical attributes that can make a perfect medical student (or any other kind of healthcare professional for that matter).

I can only be me. I am petite, I wear braces, and while those things in isolation could be reason to make me self-conscious, I realize that it’s minimal in the grand scheme of what patients — *people* — are looking for.

Someone to see them, someone to talk to. Someone who will listen.

Mrs. Red taught me that more can be said with silence than words. To take each hard-lined smile with gratitude. I realize now, that though I only saw her smile once, her bright red wig had always been there, shining with unapologetic, iridescent, curly waves, voluminous in nature and speaking volumes for her.

# MR. H

Rebecca Grove

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“Well Mr. H, looks like we are going to get to know each other well tonight.”

I was a third year medical student, working my first shift in the emergency department (ED). After showing up at the wrong time, with the wrong clothes, I had finally settled into team center C. It was the weekend and not much was happening in the ED. My first case had been a 4-year-old with 5 days of cough and fever. I succeeded in making the mom so nervous as I clumsily wielded the wooden tongue depressor that she asked the resident to please take over, strong emphasis on the please. Trying to get an ECHO for a woman with chest pain started off better, but I soon relinquished the probe after failing to achieve an acceptable view, my hand covered in jelly since I had forgotten to put on a glove. With not much to do on a quiet Saturday morning, the resident pulled me into the stabilization room as a patient was brought in after a motor vehicle accident. We rifled through drawers and, before I knew it, I was outfitted with glasses and a drill. I stood, wielding my tools with what I am sure was a look of excited terror, waiting to see if I would have the chance to place my first intraosseous needle.

I did not.

A wave of disappointment intermingled with relief washed over me.

The course of events that day was not entirely new to me. I had already experienced similar frustrations tied to my role as a medical student in the hospital. We are transient players in the game of medicine, in and out of hospitals, on and off teams. There is rarely a true need for us to be present. Most of us have deep wells of cerebral knowledge but often lack the technical skills to perform even the simple tasks of placing IVs or bandaging wounds. We do our best to be useful but have a hard time knowing what useful looks like. And so, we fumble along. I have mostly accepted this reality but still find myself at times yearning for immediate purpose, the gratification of a job well done, that comforting sense of accomplishment. Such was the reality of my first day in the ED. That is, until Mr. H arrived.

Mr. H was a 60-something-year-old man, I cannot remember exactly. Nor can I recall where he worked (a factory?), how many grandkids he had (I think 5) or what his other health problems were (hypertension had to be one of them). I was pulled along to meet him without time to look at his chart. There were no presentations to attendings, no discussions of differential diagnoses, and no complex workup. Mr. H's problem was straightforward: nosebleed. He had a history of nosebleeds, often in the winter when it was dry. Not too long ago, he had a bleed that resolved on its own. Today though, it was different. His nosebleed started suddenly at work and did not stop. He was worried that something sinister was causing the bleed, and who could blame him? That much blood coming out of your body must be unnerving. One of the residents came over to finish gathering the history, and I looked on, peeking over her shoulder. When she was assured that no trauma had occurred, no drugs had been ingested, and we knew

the patient's current medications, she explained that we had a few options to stop the bleeding which we would now attempt systematically. First step, applying pressure. She turned to me and asked, "Will you hold his nose, please?"

Hit the lights! . . . Cue the band! . . .

FINALLY! No one else needed me, no one else would miss my presence. I was at the same time completely disposable and finally useful! My skill set was the perfect match. I stepped up to the side of the bed, introduced myself to Mr. H, and clamped down on his nose with my right index finger and thumb. A strangely intimate way to begin a patient-provider relationship. While the team buzzed around, looking for Afrin and gathering nose balloons and wads of cotton, Mr. H and I chatted. We talked about how nervous he was. How much he loved taking care of his grandkids. How he had made a life for himself here in Minneapolis. As the minutes ticked by, I was reminded that I had an asset most others in the busy stabilization bay lacked. I had time.

When applying pressure did not work to stop the bleeding, we tried Afrin. No dice. Next came a small cotton plug. Still, the bleeding continued. At this point, we explained to Mr. H that our next option was to insert a longer stick of absorbent material deep into his nose and yes, it would be very uncomfortable. He and I had been talking about this earlier as I interpreted the resident chatter around us. He was ready for "whatever it takes," and who better to do the honors than the medical student who had been dutifully holding his nose for 38 minutes. As I pushed the stick straight back as far as it would go, he winced a little then said, "That wasn't bad." My heart swelled with pride. The bleeding slowed and then stopped. The attending physician approved our patient for discharge, and the nurse brought over his papers. As I said goodbye to Mr. H, he smiled and thanked me, taking my hands between his.

Maybe I do have a role on the team after all.

# FLOWS

John McGrory

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The flow of medicine is strong. The seemingly endless stream of patients pours through the hospital and clinic doors, into the rocks, and babbles back out again, both water and rocks forever affected by their co-percolation. Some in the stream find themselves stuck in eddy currents, returning to the same place over and over, while others are on a more laminar journey, perhaps meeting rocks only once or twice along their voyage through the stream. We, as medical students, are small stones placed haphazardly into these streams, shaped both by our fellow rocks and by the water that flows past. For most in the stream, we have a negligible effect, while for others, we can augment their journey quite drastically.

These metaphors are starting to hurt my brain, but, since I'm currently in my surgery clerkship, I'm going to stick to my guns. As a shy third-year student from the Midwest, I have an incessant need, perhaps to a pathological degree, to preserve the flows into which I'm placed. In some ways, this is an educational advantage, in that I'm extremely motivated to learn quickly enough so as to not stick out like a boulder in a brook. In other ways, though, this mindset can make it difficult to have the courage to make waves when waves need to be made.

The presence of the flow was most tangible during my family medicine clerkship, while at a busy suburban clinic that provided care for upwards of 25 patients per day. A single mistake with a prescription or one missed question during my interview could add several minutes to the ever-present log jam at the end of the day. And the lack of residents to buffer my ineptitude from the precepting physician only added to my neuroticism.

By the end of the second week, I started to feel the jagged edges of my stone begin to smooth, and flow through the clinic started to feel more natural. Patterns in the stream emerged and I found myself able to conduct some appointments almost completely autonomously. Recognition of my progress by my preceptor was quickly followed by genuine feelings of accomplishment, pride, and fulfillment.

Then came Mr. Sparrow. He had been in the Marine Corps for the better part of a decade, working his way up to first lieutenant just in time for the Gulf War. Halfway through his first deployment, he was the victim of a grenade explosion during a live training exercise, leaving shrapnel embedded into the left side of his torso. Some of the fragments were subsequently removed, but others were deemed too dangerous for operative intervention and remain in place today. He was quickly shipped home and promoted to captain before retiring from the military and returning to civilian life.

As a consequence of this injury, Mr. Sparrow has a constant gnawing pain in his left abdomen and hip area. He was originally followed at the VA hospital for several years but started to see my preceptor a few years ago at the recommendation of a mutual friend. A quick look at his medical record revealed a

gradual, but steadily increasing dose of narcotic pain medications since his transfer to the clinic. Although this regimen might sometimes be appropriate in certain circumstances, the concerned voices

of past professors, recent pain research (Chou et al., 2015), and media coverage (Volkow & McLellan, 2016) floated into my thoughts.

After interviewing Mr. Sparrow, I went over his medication list with my preceptor, just as I had for most of the patients we'd encountered together. That familiar feeling of flow resurfaced when I pondered whether or not to raise the question of the patient's narcotic usage, although this feeling was a little different. I wasn't particularly worried about disrupting the clinic schedule with a simple question about medication dosing. Instead, I was concerned about the flow of our teacher-student relationship and how it might be affected by the perception of a medical student questioning the decisions of an established community physician.

With some mustered courage and careful wording, I broached the subject of alternatives to Mr. Sparrow's current pain medications. My preceptor's response validated my initial feelings, and he agreed that it was an appropriate time to have that conversation with Mr. Sparrow. After the appointment, we had a discussion about the difficulties of preserving flow in balancing patient relationship expectations with concerns about long-standing medical care. He also noted that, had I not rocked the boat, so to speak, he may have let that situation continue unchanged for another couple of appointments.

As I strive to incorporate myself into the beautiful flow of medicine by taking my shape and minimizing unnecessary disturbances to the stream, I will forever remember that my presence in that stream does indeed serve a purpose and that, at times, I may be the rock in the best position to make a few waves.

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# NOT JUST A MEDICAL STUDENT

Nikki Janssen

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On a dreary and cold Thursday afternoon a week before Christmas, I walked down the hallway to the burn unit to see a new infectious disease consult. I grabbed the door handle only to be met with resistance—I had forgotten to tap my badge to unlock the door. Again. Just another moment to make me feel out of place, at the bottom of the food chain. “I’m just a medical student,” I found myself saying numerous times a day. I wondered if seeing patients and navigating the hospital would ever feel natural.

A nurse tapped her badge against the card reader and opened the door. I continued down the hall until I found my patient’s room, put on a gown and gloves, adjusted my face shield, and took a deep breath to calm myself before opening the door. As I entered her room, I was met with a smiling middle-aged woman eating an enchilada. My stomach growled as I remembered I hadn’t had time to eat lunch yet. I introduced myself the way I always did: “I’m the medical student on your care team today. I’m here to find out what brought you into the hospital and to get a better idea about how we can help you while you’re here.” The words had become second nature, but my role still felt uncomfortable. Every encounter with a patient felt like I was playing pretend. I knew, and my patients knew, that I wasn’t really a doctor.

We talked for a while as she explained how she had recently had surgery to put a skin graft from her arm onto her foot. She had struggled for months with a wound from a previous foot reconstruction surgery that was not healing due to her underlying diabetes. She had been in the hospital a week earlier with a post-surgical infection, and now she was back because the infection still hadn’t resolved. She asked me what we could do and why the previous antibiotics didn’t work. I gave her the best answer I could, talked about some of her options, and I made sure to mention my attending would be there later to go over everything in more detail.

I then asked if I could examine her, and she happily obliged. I put my stethoscope into my ears and disappeared into my own thoughts as I listened carefully to her heart and lungs, both of which were normal as far as I could tell. I continued the exam, checking her neurological status and then looking at her wounds. The infected foot was wrapped in a bandage and strapped into a walking boot. Her arm was also still bandaged from the graft surgery. *Right foot, left arm.* I made a mental note for later when I would document her physical exam. She looked at me and asked if I wanted to see the wounds. “Oh, I’m just a student,” I found myself saying yet again. “I don’t think they’d want me to mess up all the bandages.” She chuckled and said, “Well, I’m an expert at putting this gauze on after all this time. If you want, we can do it together. I’ll show you.”

She took my gloved hand in hers and directed me toward her arm first. I began to unwrap the carefully-placed gauze, and she explained how rolling up the bandage as you go makes it much easier to reapply later. I continued

unwrapping and re-rolling until her arm was exposed and I could fully examine her wound. We did the same with her foot, and then she guided me through

the process of redressing her wounds. I stayed with her for a few more minutes. We chatted about her favorite Christmas cookie recipe, the best holiday movies, and what it was like to be a medical student in a pandemic. As I was leaving her room, my hand on the door handle, she said one last thing that changed my perspective: “You’re not *just* a medical student.”

I removed my gown and gloves, remembered to tap my badge against the card reader this time, and returned to the work room to write my note. I hadn’t done anything particularly special—I didn’t diagnose a rare disease, catch an easy-to-miss exam finding, or save this patient’s life. But I had made a difference in her day, and she had made a difference in the way I saw myself and my job. As a medical student, I had more time to spend with her than any of her other providers. I could hear about her special sugar cookie recipe *and* her foot infection. After a few weeks on the infectious disease service, I did have enough knowledge to give her a basic explanation of her problem. Her kindness and patience gave me just enough of a confidence boost to go outside of my comfort zone and realize I wasn’t “messing up” her bandages by doing a thorough examination. Yes, I am still learning the basics of medicine, but I’m not just a medical student. I have a lot to offer to my patients, and those 20 minutes in the burn unit were just what I needed to realize that.

# MOM & MR. C

Octavia Ruelas

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Mr. C was the first patient I saw on my required general surgery clerkship.

He was a young man in his thirties who had been found down in front of a bar with multiple injuries. On the way to his room, the intern whispered to me that the operating surgeon had found at least twenty individual stab wounds on this patient during his emergency surgery. He was now stable and several days post-op and we were on our way to change some of his wound dressings. He had something around eleven wounds we had to prod and repack, all located around his chest and abdomen. In addition to his multiple stab wounds, he had a large chest tube placed in one of his lungs. Every movement, even breathing, was obviously uncomfortable for him. The intern and I quickly got underway, trying to distract the patient with innocuous small talk. The verbal anesthesia worked until we got to a wound over his midline abdomen. It was larger than the rest, requiring us to push a thin piece of gauze much deeper than the patient had expected.

Mr. C suddenly reached out, his left hand grasping on air as he hissed through the pain.

“Do you want to hold my hand?” I blurted.

He nodded once, and I grabbed his large, rough hand. Mr. C stiffened and cursed through clenched teeth as the intern apologized.

“Squeeze as hard as you need to,” I said, “I can handle it.”

The intern finished up shortly after, and Mr. C gave me a sheepish smile.

“Thanks.” He murmured.

“You’re welcome.” I smiled back, hoping to reassure him that there was nothing to be embarrassed about.

It was obvious to me that those few seconds of holding Mr. C’s hand had been exactly what was needed to get him through that painful process. Anyone could see that that moment was a very human one and not unusual in the many interactions between healthcare professionals and patients. It was obvious to me that though a spontaneous action, it was the right thing to do for the patient in that moment. What was a little less obvious, though, was what that moment had done for me, not as a medical student, not as a learner, but as a person.

Mr. C was the first patient I saw on my required general surgery clerkship. He was also the first patient I saw after Mom died.

Mom had passed peacefully in her sleep two months prior. She had been diagnosed with metastatic breast cancer

some time before and had been steadily declining over the past several months. Her body was weak, her muscles atrophied, her activity limited, but she was still *Mom*. Her voice was strong, her advice sound, and her faith in God unshakable.

I was in the middle of a week of pediatric overnight shifts when a phone call from my Dad woke me up from sleep. I had just been asleep for an hour after getting home from St. Paul Children's Hospital.

"Mija," My dad's voice was tight and restrained, "You need to come home."

The following month and a half was a blur. I took time off from school. I wept for hours most days with my father, my brother and my little sister. Some days I only left my room to go to the bathroom and eat. I lost weight, I gained weight, I was raw, I was numb. Some days I played music quietly in my earbuds. Other days the only thing I could hear was my dad's praying and weeping across the hall.

In the week leading up to starting back on rotations, I spent a lot of time alone in my apartment. Mourning, thinking, reflecting, wondering how I was going to get through the next hour, days, weeks, months, *the rest of my life* without my mom.

*How am I going to be able to talk to patients? How can I possibly counsel them when I'm hurting this badly?*

I didn't suffer nightmares, but I had morbid daydreams that I had completely lost the ability to speak, that I had lost my humanity when I buried Mom. I didn't feel like myself. Sometimes, I didn't feel anything at all. Despite the waves of grief, I was eager to go back to the wards, even to just distract myself from my own thoughts.

I remember putting on a brave face for my surgery team, mustering up the enthusiasm required when you first establish yourself in a new rotation. The interns were engaging (more so than I expected from surgeons) and quickly included me in their activities.

On my first day back, my very first patient was Mr. C. While I was not glad to see him hurting, holding his hand was exactly what I needed. I learned that my own suffering did not disqualify me from aiding in easing the suffering of others. My own pain did not mean I was unable to help recognize and be a part of treating it. Despite the raw grief and brokenness that I felt, that brief hand clasp reminded me that I could still help bear another's pain. I did not have to understand the pain, but I could be present. I did not have to pretend to be a hero, but I could hold a hand.

Altruism alone is not enough to get through long overnight shifts and difficult patient situations. It is not enough to reason through the abject suffering and indiscriminate unfairness of trauma and death I have seen as a student and will continue to see as a future Emergency Medicine physician. In that moment, I learned that being true to myself was just as important as incorporating all that medical school had taught me. I could still be present in a patient's pain without denying my own. I could be the doctor and the daughter. Dr. Ruelas and Octavia, too.

# A PEDIATRIC CODE BLUE

Richard C. Campbell

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It was the second week of my pediatric rotation. Monday mornings can yield conflicting zeal. Like my frozen car that morning, I needed time to warm up to full productivity. The day started with some good news; my septic kid from last week was going home today! It was fulfilling knowing that I contributed significantly towards his care. As I finished skimming through the charts, a nurse asked me about a newer patient. My fraud feeling was fleeting as I learned that it was a 3-day-old boy with jaundice. I had just taken care of two other jaundice babies with a similar plan the prior week. I agreed with the nurse's plan and reiterated that I would update Dr. M. The rest of the morning went along unperturbed until...

I was rounding with Dr. M when from a distance, I heard the code blue alarm. She started with a brisk walk that graduated to a jog, then a full-on sprint down the hallway. I presumed she realized the gravity of the situation as I mirrored her mannerism along the hallway.

"Baby stopped breathing in room two."

That room number rings a bell. Upon approaching the patient's room, the blinding blue light illuminated the hallway. My heart was racing, my thoughts; static. I could hear a high-pitched grief-stricken cry. I assumed it was his mother. I situated myself in a corner of the room, with an unobstructed view of the organized chaos.

A couple minutes into the code, I garnered enough courage to alert the nurse that I was in line for chest compressions. I had never done compressions on a real baby before. I watched his thumb placement on the baby and tried to imitate his actions. He counted down, "3, 2, 1 switch!" It was now my turn. Baby was grey and felt clammy. I had to readjust my sliding thumbs. Mom and dad who had been crying in the hallway were accompanied into the room to be with their baby. Mom was in a state of shock; her eyes peeled back in anticipation. Dad was more expressive, his face flushed with teary eyes and a snotty nose. Both, visibly in agony. She touched her baby's arm and cried out his name "... please don't leave me, you cannot die ...." She looked at me and said, "please help my son."

I held back my tears, suffocating my emotions, this was not a time to be emotional. I had to be focused with my chest compressions to her baby. "A little faster," the respiratory therapist said. A nurse on my left-hand side murmuring, "you're doing great keep going." Dr. M directed, "push x units of epi." Another nurse replied, "pushing x units of epi now." I tried to zone out mom as I focused on counting each compression. Even though codes can be oddly calm, there were occasional silent moments in the room. I sensed most people were thinking the inevitable. My heart ached for the parents. It was unimaginable how they were feeling.

It became more evident that our efforts would prove futile. Dr. M started the dreaded conversation, her face flushed,

yet, still professional and empathetic. She was a seasoned doctor, but this was still very hard for her. As she spoke to the parents, dad cried even louder, falling to his knees. Mom ceased her spiritual chants and screamed out her baby's name. Her voice clearly echoing pain I could not even imagine. Why did this seem so cruel? Part of me wanted to carry some of her burden. As I stepped outside the room, I could not hold back the tears anymore. I was visibly crying in front of people I had only worked with for a week. The atmosphere was somber, some red eyes in between and a few quiet whispers along the hallway.

The next morning, I snoozed my alarm a few times. Sleep was not the culprit, as I felt heavy-laden with thoughts from the previous day. The shower was longer than usual, as I contemplated the thought of calling in sick. The frigid walk to the car further potentiated this feeling. Why am I doing this? I asked myself. At work, it was clear I was not alone with this feeling. Whispers of yesterday's event permeated the break room and nursing station. "Veteran or rookie, these situations are hard for everyone," a nurse said. I was reassured that I was not alone with this feeling. Regardless, there were newborn babies to be examined. I had to hold a smile to mask my current mood. As I listened to the steady heartbeat of one of my patients it was like a sunray piercing through an overcast sky. Days like yesterday give greater appreciation to uneventful days like today.

# BEHIND EACH DOOR IN THE BIRTHPLACE

Christy Atkinson

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It was the first week of my first rotation in medical school: Obstetrics and Gynecology. I wandered distractedly into the charting area of the labor and delivery unit, having just come from an exciting procedure in the OR. I noticed a nurse quietly waiting for a provider. Pacing back and forth, she asked if I was one of the residents. I replied no, that I was a medical student. As I responded, I noticed with unease her red, tearing eyes. She said, “We have a patient that really needs to be seen, where is everyone?”

The amazing procedure I had just finished was a scheduled C-section, made all the more thrilling for me as I was first assist—for the first time—after the other OB’s and residents were pulled away to an emergent C-section in the OR next door. I was riding high after the new experience, so it took effort to quell my excitement as I explained to the distressed nurse where the physicians were.

Then I asked the question I feared I wouldn’t be able to answer as a medical student: “What’s wrong?”

“I couldn’t find a heartbeat. She’s 40 weeks. She came in for decreased fetal movement.”

My heart dropped to my gut. “Oh no.”

I rushed out to find the doctor I had just assisted in the C-section, Dr. Brown. She had already stayed late to help her colleagues who were tied up in the OR with the emergent C-section, so we waited a few minutes for the physician who was on next for the night shift. Knowing what might lie ahead for this patient, who now carried a deceased, full-term baby, Dr. Brown thought the physician who would deliver the horrible news should also be the one to assist the parents in the inevitable, gut-wrenching process.

When the night-shift physician arrived, after what felt like eternity, Dr. Brown explained the situation. I asked if I could come with her to see the young patient and her husband. It was going to be their first child, a child that was planned, anticipated, and welcomed by this bright young couple. I had not seen bad news delivered before, and I knew exposure is important early on. I want to get it right when it’s my turn down the road, and this seemed like the worst news a doctor could give to a patient.

We hurried on our way to the patient’s room. Her nurse had turned from distressed to angry, knowing that the patient had been sitting with her husband all this time as they waited for a physician. The nurse had not told them what she had not found. But for two future parents who attended so many prenatal appointments together, they had to know what it meant when there was no whooshing on the fetal Doppler, no movement of the little form on the ultrasound.

What came next was as sad and terrible as one might predict. I didn’t stay the night for the induction of labor, but

when I returned the next morning the same doctor was in the patient's room: mom was now pushing. It wasn't my place to enter the process at this stage, so I stayed out. I went through the day thinking about all the joy on our unit, except that one room.

Later that night I looked down the long hall to see the parents tearfully making their way to the nursery. The other patients on the unit had no idea what was going on just a few rooms down, but this young couple knew exactly what they had been robbed of, as they moved like ghosts to say goodbye to their baby amidst the happy bustle of the unit preparing (mostly) for new life.

This is a story I carry with me now as I move forward in becoming a doctor. I will always remember the looks on the parents' faces as they were told there was no heartbeat, the air of tragedy that lingered in the unit all week, the awful feeling that life moved on with terrible normalcy despite their tragedy. Knowing that devastation will have its place in the corners of my future practice does not deter me, though. Having the opportunity to see a well-practiced, kind OB guide this couple with grace through the process showed me what an amazing difference a provider can make. There are parts of life that are unbearable but inevitable; we as physicians are bestowed the opportunity to practice the art of medicine to make these parts a little less traumatic for our patients.

# A PATIENT'S STORY

Danielle Aase

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Several weeks of fevers and fatigue. Prosthetic heart valves. Recent dental work. What's your differential diagnosis? Don't anchor, I told myself, try to think of possibilities other than endocarditis.

It was the second day of my internal medicine clerkship and my first full rotation of my third year. I was excited, albeit a little apprehensive about the notoriously demanding internal medicine clerkship. I picked up a patient on my first day, but the patient sitting in front of me was my first admission, my first chance to see a patient through an entire hospital visit. She arrived with her son, who helped fill in the gaps in her story. I learned not only about her current illness, but also about their difficult year. The patient's father recently died a few months before, so she had initially attributed her fatigue to the stress of his death. She presented now because her symptoms had persisted for so long.

I diligently asked her about her fatigue and fevers with the OPQRST mnemonic as I had been trained to do for the previous two years. I checked all of the boxes: past medical history, surgical history, family history, social history, medications, and allergies. As we talked, my differential diagnosis started to arrange itself, with endocarditis at the very top. In medical school, we often learned the typical presentations of diseases as "stories", and her symptoms matched the "story" of endocarditis almost exactly as I had learned it. After I left the patient's room on the first day, I was excited not only about the educational experience, but also about the opportunity to hear the patient's own story beyond her symptoms.

We quickly diagnosed her with endocarditis and followed the blood cultures closely. I saw her twice a day, with a shorter pre-rounding visit in the morning and again for a longer visit in the afternoon. As a medical student carrying only 2-3 patients (a luxury), we chatted about many topics outside of medicine and I got to know her as a person rather than as the patient with endocarditis. We talked about her cats, my apartment hunting, and everything in between. I even met her family when they visited. At one point, she told me that she had waited to talk to me about a noisy infusion pump because she "knew I would actually do something about it". I felt like a doctor that day.

On the day of her heart surgery, I anxiously checked her chart all day for any updates. When I saw a brief post-operative note, I breathed a sigh of relief. Everything had gone well. I went home that night with a weight lifted off my shoulders.

The next morning, I looked in her chart again to find her new room number. She had switched off of our team, but I hoped to visit her later that day. However, when I read the final post-operative note, my heart sank and my stomach twisted into a knot. As they were preparing to leave the operating room, her blood pressure dropped and they were unable to get it back. She died without ever waking up from the surgery. As I read the matter-of-fact

details in the note, I pictured the entire scene in my head, and thought of her family members anxiously awaiting news in the waiting room. My heart broke for them.

That day, I had a hard time concentrating on my other patients. When asked about the complications of cirrhosis, I couldn't think of a single one. We had done everything right, I thought. What else could we have done? I cried when I got home.

In the days afterward, I tried to come to terms with her death and what it meant to me. We had done everything right: the diagnostic workup, the consultations, the medications, and yet, it wasn't enough in the end. I objectively knew before starting medical school that there would be situations in which, despite our best efforts, the outcome wouldn't be a happy one. However, I wasn't prepared to learn this lesson first-hand so early and so unexpectedly in my third year.

I will be forever grateful that I got to play a small part in her care. In caring for her, I cared for myself. After spending countless hours studying, seemingly without end, during my first two years of medical school, I finally had the opportunity to experience how truly rewarding medicine can be. I am thankful to have experienced a relationship strong enough to make my heart ache as it did.

Talking with her every day reinforced why I wanted to go into medicine in the first place: to form meaningful relationships with patients. Medicine is about stories: the story of your patient's symptoms, which you take and reconstruct into a different type of story to communicate to your colleagues and document in the medical record. Then there is the equally if not more important story of how the patient's current symptoms fit into the larger story of their life. It is our responsibility as physicians to hear not only the first type of story, but also the second. I had the privilege of hearing a tiny portion of my patient's life story every day, which over the two weeks I knew her, built itself into a substantial narrative that I will carry with me for the rest of my training and career.

# DOES SHE KNOW?

Jacob Krogstad

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The lights were bright and hot as I looked down toward the patient underneath the blue drapes. Every step of her operation had gone perfectly and now it was time to close. We had just completed her abdominal hysterectomy and I still couldn't believe that I had held her uterus in my hands. I was enthralled with the entire process of the operation and now here I was, a third year medical student on his first day in the operating room holding the organ that grows another life. I was amazed at the skill and ease with which the surgeons operated and it filled me with energy and dreams of my future career where I might one day be the surgeon performing this operation. In the excitement of seeing my first operation, I had nearly forgotten the patient underneath our drapes. I had forgotten that my excitement came because of her pain and discomfort. I did not know this patient well, having just met her that morning before surgery, but she was a very sweet and kind woman who was more than happy to allow the student into the operating room. As she was being prepped and I was scrubbing in with the surgeons I began to wonder. Does she know that this is the first surgery I will be in?

Once the operation was complete and the incision was being closed, I started to feel a combination of anticipation and nervousness. I had a feeling the senior resident was going to ask if I wanted to assist with the final suturing of the skin. I thought that I would be ready for this moment with all of the practicing that I had done at home during my virtual clerkships during the height of the pandemic, but suturing fruit or rubber models can only get you so prepared for the real thing. When the senior resident asked the surgical tech to hand the needle driver to me I immediately felt my pulse quicken and a drop of sweat run down my back. Even though I had been hoping for this opportunity to come, I still found myself full of doubt and unsure of my skills, which put me in a strange position. As a student I want every opportunity to learn and improve my skills, but I also want to make sure that the patient is getting the best care possible. It's hard to imagine that the best possible patient care includes letting a medical student close a wound. Does she know that this is my first skin closure on real skin?

The first few stitches went well, but when I looked up and saw how quickly the resident was working, I became very aware of how slowly I was working. When I tried to move a little quicker my hands began to feel clumsy and uncoordinated. My hands were far from the steady hands a patient would expect their surgeon to have. What if the patient knew how much my hands shook? Once the resident noticed this, she gave me words of encouragement. She reminded me that it's okay to take my time, and told me that I was doing a good job. But still, I felt guilty because was my good, good enough for the patient? Wouldn't it have just been better to let the resident close the skin? With the support and encouragement of the resident, I eventually finished my portion of the skin closure, and I felt very proud and accomplished—the sutures I put in looked good. Then I started to worry. What if I messed up and they came undone, or left my patient with a scar? Would my learning have really been worth it for her then? Did she know a student would be placing any of her sutures? And if she did know, would she have let me?

As a medical student I am constantly finding myself in these strange and uncomfortable situations every day that I work with patients. I am always eager and excited to do new things, but there is always a thought in the back of my mind that asks, is it really the best for the patient if I do this instead of the attending? The easy answer is no, but then I would never be able to become the physician I desire to be. I am grateful for every opportunity that my patients have given me to learn, and the woman from this surgery is at the top of my list. She didn't know that I would be there when she scheduled her surgery, and she didn't know that I would have any hand in it. So now I sit and wonder, does she know how grateful I am, and does she know how honored I feel to have been part of her care? I hope she does.

# DEAR JOHN

Rachel Oldfather

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Dear John Doe –

I only met you once in the operating room, and I wish I knew who you were. I have seen inside your body but have never seen your face. While you were exposed and vulnerable, I didn't hold your hand. Instead, I held your aorta.

Your surgery had already started when I arrived. You were already asleep with your abdomen open and defenseless against the air in the operating room. Even so, you seemed more at ease and prepared to be there than I was. My preceptor had finished for the day and sent me into your surgery; I had never seen a case like yours before.

Your name was written at the top of the large whiteboard in your operating room, but I never looked at it. Instead, I learned the name of your surgeon and tried to decide where to write my name. The board provided designated space for common key players found in the OR:

Attending  
1st Assist  
Surgical Tech  
Scrub Tech  
RN  
Medical Rep  
Observer

Which one was I? Honestly, I wasn't sure and added my name at the very bottom, in the physical gray area between observer and an otherwise undesignated role.

The conversation being held over your body about the recent holiday party lulled long enough for me to introduce myself and hand my sterile gear to your scrub tech. Your surgeon greeted me with a slight nod.

When I returned, ready to help with your surgery, I slowly inched towards your open belly. "I won't bite," your surgeon reassured me, "this is surgery, you should get used to being close together. No use being shy here." I think he was being kind rather than critical, but I had heard too many warnings about surgeon personalities to trust his tone of voice. I don't remember replying, but I did settle in close to him.

Instead of the standard conversation ice-breakers asking where I go to school, what year I am in my training, or what specialty I will choose, your surgeon asked me to name the anatomical structures he should be sure not to damage. I forced myself out of the slight daze triggered by the offensive fluorescent lights and the smell of recently used cautery. If I am going to help with your surgery, I really should be able to answer this question.

Think. Think. “The iliac vessels?”

“Is that a question?”

Kind of, yeah. It was the first thing I could think of while trying to mentally reconstruct that day in anatomy lab when we dissected the abdomen and pelvis. Your beeping vitals monitor and my bloody gloves distracted me from maintaining focus with a clear head. Arteries are always important, though. So I respond, “no, you need to watch out for the iliac vessels.”

“Very good.”

Apparently, I passed this initial round.

We held light conversation over your open body; it is amazing how much you were able to withstand. I learned the name of the retractor system used to hold your skin out of the way and was excited to hold tools while your surgeon worked. I entertained myself with your magnificent bowel. Touching it just right induced peristalsis, even while you were paralyzed and heavily sedated.

I will admit, I was not prepared for the day we met. Usually, I will familiarize myself with a procedure before arriving, but I did not get the chance to review your story before meeting you. I was grateful that your surgeon did not test me on the intricacies of the procedure, I think that would have been painful for everyone in the room, except you, perhaps. You might have been the only person spared from the embarrassment when it’s revealed that I mostly did not know what was going on.

Your surgeon paused with his work and dug around for something in your belly. I hoped that he hadn’t dropped something. With his other hand, he grabbed my forearm and guided my hand into your belly until we were swimming up to our elbows in your bowel.

“Feel that?” he asks.

“Yes,” I can barely form the word and spit it out.

“That’s the aorta,” he says, just to be sure we were all on the same page, “don’t squeeze too hard.”

I felt the strong, pulsating vessel in my hand and thought of the first aorta I held two years ago; the aorta of my “first patient”.<sup>1</sup> My first patient, the donated body that three of my classmates and I dissected in the first few months of medical school, is the crux of my understanding of human anatomy. He is the one with whom I compared your anatomy. His aorta was stiff and only slightly flexible, and I do not remember being very impressed by it. Your aorta was incomparable. Yours was full of life.

Holding your aorta felt similar to my attempt at wrapping my brain around the idea that Betelgeuse may be

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1. Ferguson, K. J., Iverson, W., & Pizzimenti, M. (2008). Constructing stories of past lives: cadaver as first patient: “clinical summary of dissection” writing assignment for medical students. *Perm J*. 2008 Spring;12(2):89-92. doi: 10.7812/tpp/07-145.

exploding right now, which means that it already exploded 600 years ago.<sup>2</sup> To the universe, stars exploding are commonplace. A star just like our Sun explodes about every second somewhere in the massive universe.<sup>3</sup> Perhaps a star is important for a time but its moment to shine is still only temporary. Just like a star exploding somewhere out in the universe, your aorta was both momentous and also mundane.

From outside my body, I observed myself holding the route of your blood supply. My presence in your OR—in any OR—is temporary, but that did not seem to matter anymore. Just moments ago, I had been preoccupied with my own performance and identity and did not think about yours. The impact you had on me is permanent, and I am sorry that I do not know who you are.

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2. Drake, N. (2019, December 26). A giant star is acting strange, and astronomers are buzzing. National Geographic.

3. Phillips, T. (2014, August 26). Evidence for Supernovas Near Earth. NASA Science.

# ME AND MY DRUM

Julia Weston

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My hand fumbled around inside a man's abdominal cavity until intestines swirled halfway up my forearm. I desperately tried to feel the tumor the surgeon told me to find, all while "The Little Drummer Boy" played on the speaker overhead. I asked myself: *How did I get here?*

Here I was, a third-year medical student getting truly "hands-on" experience in the Operating Room a week before Christmas. I stuck out easily from the crowd in the hard, gray room. Everyone meticulously swayed around the patient and I as if it were heavily rehearsed choreography. Meanwhile, my eyes delineated a clear sense of self-doubt with a furled brow, my ceil blue bouffant stuck straight up from my head, bumpy like the petals of a flower when a child holds it out of the car window, a slick of sweat permanently plastered under my hairline, my fogged safety goggles making their continued journey down the bridge of my nose. Everyone else bore holiday-themed cloth surgical caps over their slicked back hair, knew what and what not to touch, what and what not to say, their role and place in the OR as obvious to them as the sky is blue. To me, the sky might as well have been technicolor as I calculated my every move three times.

*Where is this dang tumor?* I asked myself, my fingers scoping around the man's pelvic cavity while the colorectal surgeon scanned my facial expressions, seeming to correctly decipher what each crinkle in my skin meant as I obviously feigned the look of a true intellectual who knew what I was doing. The surgeon nodded at me as if to say, "you gotta go way deeper in there." The bottom half of the patient's abdomen had been surgically opened and explored by the meticulous fingers of the surgeon, and my one job was to find the tumor in the patient's colon by feel, my vision obscured by intestines swallowing my arm whole. I could feel the heat of the surgeon holding back chuckles as I maneuvered my body to accomplish the task. *I have no gift to bring, pa rum pum pum pum...* Now I was up on my tip toes on the metal step provided for my short stature, trying to maneuver my forearm further inside this man's abdomen. *Maybe if I bend my arm a bit... no, flex the wrist, put your fingers together like a duck's bill, put your weight into it,* I pretended to coach myself. *Yes, that's the rectum that courses into the pelvic cavity. Finally, I think... I think I found it:* an area at the junction of the rectum and sigmoid colon, definitely meatier and more rubbery than the surrounding smooth, slippery tubular structures. I let out a mental sigh of relief and looked up at the surgeon.

"I found it," I told her half-confidently with a squint of the eyes in an attempt to convey a sense of calm and peace over my blood-spotted mask. *I played my drum for him, pa rum pum pum pum...*

"You sure?" she asked, apprehension in her eyes.

I nodded and began my hand's upward ascent into a world that did not involve desperately grasping a stranger's

rectum. *Maybe I impressed the surgeon by my eagerness to be involved in the case*, I thought as I cautiously coaxed myself into a feeling of belonging in the OR. *Maybe she appreciates my curiosity to learn about the human body.*

My forearm and hand emerged and were met immediately with the cold of the Operating Room, trembling like a newborn who has just been ejected from a cavern of warm, embracing fluid. I stared at my appendage, glistening with peach-colored intestinal goop and streaks of blood. Not knowing what to do with this fine specimen, I held my arm out in front of me, several IQ points having suddenly been deleted from my brain with a single click. *This way I definitely will not break sterile field*, I thought, a visceral fear that constantly coursed through my being while in the OR. The surgeon and physician's assistant howled in laughter, and the physician's assistant grabbed my arm to wipe it on the blue surgical drape for me, a task my brain could not compute on its own. *I played my best for him, pa rum pum pum pum...*

"I will never forget that," the physician's assistant chuckled.

I laughed with her, not in an attempt to fit in in the OR for once, but a genuine guffaw at myself, the complex setting in which I was stationed, and what I had just successfully faced. The truth of the matter was that I'd had a strong fear of starting my surgery rotation since the first day of medical school. Not only had I stood for several hours, overheating in a blue gown that smelled of crayons, my stomach crying for a morsel of sustenance while my blood glucose steadily dropped, I had just weaseled the majority of my forearm into a patient's pulsating belly. I probably didn't find the tumor, despite my clearly high level of expertise in the matter. But it didn't matter. *I didn't panic!*

Emotion welled up at the superior aspect of my oropharynx, when suddenly the distinct clang of a surgical instrument struck the floor, a sound which reflexively brings all who roam the OR to a cold stop. The surgeon looked up sheepishly at the physician's assistant and I across a pile of glistening intestines, her empty palm opened directly to my field of vision as if to show its shared humanity. It was then that all three of us roared in laughter. The circulating nurse playfully rolled her eyes on her way out of the OR to grab a new instrument while the dropped one lay on the floor like an overturned beetle, its metallic legs beating without rhyme or reason in the air. I was finally starting to relate less with the feeling of being an overturned beetle myself, having been reminded of the natural fallibility present in everyone in the room. I hummed along to the rhythmic buzz of the speaker overhead, joining in the sway of bodies in the room.

*Me and my drum...*

*Rum pum pum pum...*

# A CAROTID ENDARTERECTOMY SONNET

Baila Elkin

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Your neck, seen on the CT, shades of grey  
laid open now, no longer black and white  
the jugular a softly pulsing sight  
each vessel tied, each nerve out of the way  
We place the shunt, I'm suctioning the spray  
of so-much blood and swallowing my fright  
The lamps above now seem too harsh, too bright  
reflecting glints of scalpels on the tray  
I hear the rush, my own blood in my ears  
but now at last the shunt is snugly in  
the high-pitched doppler whoosh allays my fears  
with blood-flow to the brain we can begin  
to gently pry a plaque built up through years  
and close the layers, artery to skin

# SHROUDED

Allicen Waxlax

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She entered the room for her daily meeting with our team. She had been on this inpatient psychiatric ward for several days already but it was Monday morning so she would be greeted by some new and unfamiliar faces. I was one of them. She was covered nearly from head to toe in lengths and layers of clothing and she wore a bath towel tied around her head as if it were a wedding veil. She was exceedingly thin, an aspect which was still quite evident despite her many layers. Her frame supported her garments with the same effect as clothes hangers holding their wares in a closet.

Just before she had entered, I was informed that she would be my patient to follow for as long as she was still admitted during my two-week Psychiatry rotation. As a result, it was my task to start our daily interview. I worried how frightening and offensive our sheer volume would be to her: a care coordinator, an attending physician, two residents, two fellow medical students, and myself. I remember the unease I had in knowing I would be asking her questions, being someone she had never met before. But I was hopeful I could convey enough empathy in my conversation to blanket us all.

As she sat down, I will never forget my first glance into her eyes. I saw nothing. “That must be wrong,” I thought to myself, “I must have looked too quickly.” But again, I looked and was internally startled to find a void. I had only seen such absence, such shroudedness, in a few of my previous Alzheimer’s patients, but never in someone so young. She was my age and I think this disconcerted me all the more as I continued to search her eyes. It was as if her soul and essence had been a lamp covered with a thousand shawls to obstruct its glow. A gaze so tenebrous, I was caught completely off-guard.

As I asked her my questions, she would look from me to the group and back. There were no expressions in her face or body as she replied. Her words were brief, apathetic, and void of all intonation making them very dry and bitter to take, as if she were serving us dry rye crisp with no butter. She affirmed my questioning that she did in fact feel as if she may harm herself, a definite red flag. This symptom caused us all great concern, requiring a change in care plan to provide 24-hour direct supervision for this poor woman, cloaked inside and out. Remaining expressionless, she quietly arose from her chair and walked out of the room at the end of our meeting.

The next morning, before we were to meet again, our team was alerted of concerns from the charge nurse. “She was up walking all night,” the nurse began, “The staff walked all night to keep up with her. She never laid down, just kept pacing the hall from one end to the other. And what’s worse is, she has no shoes! She has been walking all night in her slipper socks on our hard floor.” A second red flag, and care plan concern, for this unfortunate young woman. Another flag she further affirmed during our daily interview shortly thereafter. She said, in her unchanged affect, that she had walked all night to keep from hurting herself. She said the only way she could feel somewhat

safe was to walk continually and sing hymns to herself. I had never seen someone so uneasy, so perseverating in their body movements, and yet so flat and devoid of all expression. Our team hoped she was only overmedicated. We discussed with her that we thought this may be a side effect, that medications would be decreased, that new meds would be started. Then we would have to wait to see if our changes would be helpful. She apathetically agreed.

The morning of my third and fourth days on the ward resulted in the same interactions with my patient. She remained draped with the same clothes I had seen in her since the first day we met and with the same towel wrapped around her head. No change in affect. No change in motion. No change in shroudedness. But, on day four, there was one change. . .on her feet. She finally had shoes, kindly brought in by her mother the evening before. I surprised myself in how much seeing shoes on this woman's feet brought me relief and comfort. Despite her tragic situation, we had achieved some protection for her, even if only for her feet. She wore them without dispute and continued to walk, incessantly, reminding me of the ever-moving monotony the taffy puller figurine has as he turns his perpetual crank.

On day five as I entered the ward, I expected to see her as I had for the last three days, mid-lap, headed down the only hallway of the ward, but she wasn't there. Was she okay? Could she be resting? Oh, how I hoped that would be the case. When it was time for her daily interview, she entered our room in new clothes, a new towel on her head, and a couple other surprises; a slight upturn to the corners of her mouth and a new tip of her head as she spoke. As I looked into her eyes this day, I saw a glimmer. That must be wrong, I thought to myself, I must have looked too quickly. No, there really was one! It was the first glimmer I had ever seen in her. My soul jumped in recognition of that small light she emitted. She had enough light now to be able to break through her void, like a single firefly disrupting the darkness of a moonless night. Such a small precious twinkle, a twinkle of hope. Now the team could again make adjustments in her medications after discussing them with her because the first changes were starting to help. We could stop the 24 hour watch too, as she was able to tell us that she didn't feel she had to move all the time and that she no longer felt unsafe to herself. As I left the ward later that day, I had more hope for her than I had felt all week. I would now await the coming of the next Monday when I could check on her again.

My second week came bringing with it more good news each day. Although in small increments, each day revealed more expression, more emotion, and more hope. For the first time since I met her, by Wednesday, she used the words "placid" and "hopeful" to describe how she felt. Instead of the "okay" she had reported every day previous.

As I left the ward on my last day I knew her journey back into the light, back from under the thousand shawls that covered her lamp, would not be hurried. It would instead be gradual and ongoing. I knew her journey would, at least for now, remain burdened with shrouds, isolation, and sometimes sorrow. I saw her soul as being so brave, slowly walking on its pilgrimage from tenebrosity to light.

She is on a journey that I, in some ways, parallel with her through my attendance in medical school. My soul is shrouded with the thousands of pages I have yet to read, thousands of practice questions and several exams I have yet to take, hours of course work I have yet to complete, and the innumerable diagnoses I have yet to decipher. Yet as I strive daily to complete these tasks I too remove, slowly, the tenebrous layers that cover the light of my soul

as a physician. Amidst the hope of the resurfacing of our light, we have similar burdens of shrouds, isolation, and sometimes sorrow.

These journeys can make us feel lonely at times, but with our families and our supports by our sides, I know we will not be alone. As we walk, we are surrounded by many who offer encouragement and refuge. I know our hearts are grateful for the gifts and protection they provide us as we walk toward our reemergence. I hope our souls continue to be persistent and brave, to uncover our light and show our potential. I hope the hymns we sing in our hearts and the shoes we wear on our feet give us the courage, strength, and protection needed to keep navigating our parallel journeys.

# YOUTHS

Daniel Ly

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“You would love the Eddy I know. The Eddy I know is loving, kind, talented, and so funny it hurts. This kid you’re seeing isn’t the Eddy I know.”

Those were the words of a father at his wits end, pleading with the medical team at the adolescent outpatient psychiatric hospital not to give up on his son. Fifteen minutes earlier, the attending child psychiatrist, Dr. Erickson, and I were sitting down in the lunchroom with Eddy. He was a sagging figure rolled up in his high school hoodie, face down in his laptop, desperately searching for an escape from the anxiety that had brought him into the treatment program. Eddy sat there one week out from his graduation from the program looking far worse than when he first arrived. It was hard to imagine this kid was once a high achieving theater student with college dreams and big aspirations.

The adolescent unit of the outpatient psychiatric ward was run less like a hospital and more like a high school. Teens at risk for substance abuse, post-traumatic stress disorder, major depressive disorder, eating disorders, and other issues spent their days working through therapeutic activities or making up class credits among supportive peers to hopefully move towards a return to their old life. To those kids, whatever struggles burdened their existence beyond the walls of the unit did not matter. All that mattered was striving to heal from their pains. The walls of the hallway were lined with art projects and positive words that lit the hospital wing with a warm light. Despite this, the lunchroom’s lone figure, backlit by the storm outside, pounding on the windows, drained the room of emotion.

“You guys, I’m taking the antidepressants and my sleep is fine, but I just can’t build up the energy or motivation to go to class. Why do I feel like this?” Both his trauma and diagnosis of Major Depressive Disorder were palpable in his slow drawl that oozed with the effort of pronunciation.

I was stumped. Any progress Eddy had made in the past few weeks seemed erased. Four weeks total. That’s all he had. If we had only one week to turn Eddy around 180 degrees, I was certain the inpatient locked unit would be admitting him in the coming weeks. The insurance caps on maximum treatment length looked like a noose around Eddy’s wellbeing right then.

“I’m sorry you’re feeling this way today, Eddy. It means a lot to us that you made the effort to come in today even though you aren’t feeling the best. Would you be able to at least attend group therapy? I bet it will give you some insight into what you might be feeling. We’ll give you some space.” Dr. Erickson gave off an air of compassion and confidence that experience affords you, but as he and I filed out of the lunchroom, his body language seemed to betray a small sense of confusion and concern. The same thoughts flooded my mind 100-fold after seeing Eddy’s presentation.

“In your experience Dr. Erickson, how often do kids like that bounce back and end up doing well outside of treatment?” A second passed and Dr. Erickson responded with a cryptic, “You’d be surprised. We’ll see what Eddy looks like tomorrow.”

The next day we were once again met with a sole figure sitting in the lunchroom with his laptop, but this time his posture gave off a strangely optimistic tone. Eddy sat up straight, college hoodie down, playing music from his computer as Dr. Erickson and I entered. He spoke with enthusiasm and energy that contrasted sharply with his previous presentation. I could almost see the individual neurons in Dr. Erickson’s brain flipping through the DSM-V ruling out new mood disorders. As my own neurons were flipping through mine, I ultimately came to the conclusion that teenagers are an enigma.

“Eddy, I have to ask what happened between yesterday and today?” Without hesitation, Eddy responded with a thoughtful message I would not forget. “I went to group therapy yesterday feeling pretty bad about my life, and the therapist wasn’t dealing with any of it. He started throwing jokes my way and really pointed out the absurdity of how I was acting and thinking. He got me to laugh at myself. I went home, put on some comedy videos and music, and I just felt like the absurdity of my life was actually pretty funny. I guess I just needed some perspective.” With my jaw slightly agape, I glanced over at Dr. Erickson, who gave me a shrug and a smile. He was not surprised. He and the therapist had known something I did not.

At Dr. Erickson’s suggestion, I tracked down Eddy’s therapist and dissected his reasoning for how he knew to make fun of the sad, depressed kid in his group session. “Oh, Eddy? Yeah, he was too caught up in himself. I knew he was just having an off day and needed to chill out a bit. I knew he could handle it because I taught him how. He’ll be fine.”

I learned three big things that day that I will carry with me in my practice: I learned that taking steps backwards doesn’t mean you are not making progress. I learned that finding a new perspective can help you heal. And lastly, that young people are incredibly, beautifully resilient.

# THOUGHTS OF AN MS3

Madison Duppenthaler

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I was inspired to write this after the orientation sessions of “Becoming a Doctor Part 2” when we listened to other medical students share some of their reflections. They were raw and real and conveyed many of the emotions I was feeling at the time. I figured if that was so encouraging to me, I would love to do the same for doctors, students, parents, and moms.

“Thoughts of an MS3”

Do I have what it takes? Should I even be here? Am I qualified? What did they see in me when they accepted me into medical school? Could I have done something else with my life? Anything else with my time? Could all my skills serve me in a different career field?

These thoughts creep through my head daily. The weight of them gives me feelings of weariness. The constant attack from myself to myself. This shouldn't be what it's like to finally achieve my dream of getting into medical school and becoming a doctor. This is harder than I thought. I feel like no one at school cares. They are so focused. They study so much harder than me. Maybe I should look for another job. I know I am talented, capable, and have an amazing work ethic. But lately it doesn't feel that way at all. I didn't know it would feel like this.

Should it feel like this? Is my passion dimming? Do I have a passion for medicine anymore? What is my passion? Am I lost? What would my family think if I changed my plan? Would they look down on me? Would they be less proud of the woman I am becoming?

My thoughts get heavier and heavier. The pressure increases and increases. I have never felt this way before. I have always been so full of hope and determination. Now the competition and the test after test determining my future and my capabilities to perform a job. It is just a job after all! This isn't my life.

Where did my fire go? Can anyone help me gain clarity? Does anyone else feel this way? Am I all alone?

No. No. No. I can't be the only one. I reach out to friends. I ask other medical students. I allow myself to share these thoughts and questions with other students, so that I can be sure I am not alone. It seems that these thoughts patterns, for the most part, are shared by many. Almost everyone has felt this way at some point. I must not be so far off in where my thoughts take me. But it shouldn't be this way. We were hand-picked. Someone saw that fire in us, but they didn't help it stay ignited. The structure of the system was like a large bucket of water that took away my flame.

Am I too deep? Is it too late to turn back? Has anyone tried before? How will I pay back my student debt? Even if I did become a doctor, how long would it take to be loan free?

I don't know. He doesn't know. She doesn't know. This is a heavy burden to bear. There is a price to pay for this type of education. Then I hear a whisper, a still small voice. I am supposed to be here. I am made to be here. I am worthy to be here. I need to press on. I need to finish strong. I have a future family to provide for.

Do I want to start a family? Is this the right time? When is the right time? Will there ever be a right time? What will my parents think? What will my mentors think? Am I capable of being a loving mother right now? Do I have the time to raise a child and give them the love and affection they will undoubtedly deserve?

My heart screams, YES! My brain begins to think and think of all the ways it could work. I began to talk to my husband, family, friends, and faculty about how it could work. I knew I could make it work.

Is this really how it has to be? Is this what it is going to take every time we want to add a child to our family? Should it be this way? Can it be different? Can I make it different?

I announce my pregnancy. Everyone is excited. Or maybe everyone acts excited. My dad asks how this will affect my education. My grandma asks how this will affect my education. My aunt asks how this will affect my education. My answer, it shouldn't.

Who knows what will happen? Will this be a routine pregnancy? Will my education be delayed? Will my graduation be delayed?

It is all out of my control now, but I have so much hope, happiness, and excitement. Feelings I hadn't felt much of since starting this journey to become a doctor. To me, there is more to life than becoming a doctor. And that, everyone, is completely alright.

# WHAT DO I WANT TO BE WHEN I GROW UP?

John McGrory

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I am a medical student nearing the end of my third year, and I still have no idea what residency I want to pursue after medical school. For those of you who are blissfully unaware of the intricacies of this exciting, yet daunting transition in medical education, I'm really getting low on time. I think it's safe to say that I've graduated from the "cute and inquisitive" exploration stage and am rapidly approaching the "OK, this guy has some serious commitment issues" stage. I can't quite put a finger on when this transition took place, but I think it was right around the time that my well-rehearsed, equivocal response to the oft-repeated specialty inquiry started to elicit concerned looks and hurried, probing questions instead of the "Oh, you have plenty of time" that I had gotten used to. I admire and envy the growing group of my colleagues that have firmly established their choice for this next step in their career. I imagine that this decisiveness extends to all facets of their lives: they're probably able to select a movie within seconds of opening Netflix and have no trouble choosing a venue for group dinners. How nimble they must be when they are picking out their outfits in the morning and when they send texts to their crushes. Although each new convert to this group turns up the internal pressure on my decision-making, each one also serves to inspire. Clarity, however elusive, is apparently achievable.

So, how does one decide? "Find out what's important to you, explore the different options, and choose what fits your needs and desires best." "Find your people." "Figure out which specialty's 'bread and-butter' can keep you interested and engaged." "Do what feels right." "Ask a mentor for input; they know you best."

All sage advice, and all heeded to the best of my ability and circumstances. Although

insight-provoking, this guidance has just felt a little too subjective to me. I've been described as a numbers guy, and all this talk about "feel" and "fit" came off as hopelessly abstract. So, in hopes of shedding some light on my future, I'm going to attempt to make this decision in a little more quantifiable terms. In fact, I'm going to throw some math at it. Now I'm not desperate enough (yet) to believe that all I've been missing thus far is a simple calculator. However, I think plainly laying out the different components that feed into this multidimensional decision will help to sort through my thought process and, hopefully, help illuminate the next step in my professional journey.

The way I see it, there are several objective-ish elements of each specialty, including, for example, post-training compensation range, amount of clinic time, degree of continuity in one's patient population, etc. On the student side, there are associated "importance" values that indicate how significant each factor is for that student in the decision. Examples could include importance values like  $I_{money}$ , which if high, demonstrates a student highly valuing income, or  $I_{clinic\_time}$ , which if negative, would mean that the student would rather write reflective essays all day than spend their working hours hanging out in a clinic. For a particular specialty, if we multiply each factor's score by the student's perceived value of that factor and sum all of them, we can obtain a score for that specialty.

Rinse and repeat for all the different specialties, and the highest score wins. Simple, right? Let's see what a general equation might look like:

$$\begin{aligned}
 \text{Score}_{\text{specialty}} = & \text{Compensation} \cdot I_{\text{money}} + \text{ClinicTime} \cdot I_{\text{clinic\_time}} + \text{Continuity} \cdot I_{\text{continuity}} \\
 & + \text{ResidencyLength} \cdot I_{\text{training\_length}} + \text{Procedures} \cdot I_{\text{procedures}} + \text{Geography} \cdot I_{\text{geo}} \\
 & + \text{SenseOfResolution} \cdot I_{\text{resolution}} + \text{FellowshipOpportunities} \cdot I_{\text{fellow}} \\
 & + \text{FamilySocietalExpectations} \cdot I_{\text{politics}} + \text{AmountOfFreeTime} \cdot I_{\text{free\_time}} \\
 & + \text{AdultToChildrenPatientMix} \cdot I_{\text{patient\_mix}} + \text{TimeInDarkRooms} \cdot I_{\text{dark\_rooms}}
 \end{aligned}$$

To give an example for a particular specialty, one could describe family medicine, again in objective-ish terms, as a specialty with high clinic time, high continuity, and low relative residency length. Neurosurgery could be described as having low to moderate clinic time, high residency training length, high proportion of procedures, and a low amount of free time. There are, of course, nuances in how different programs within one specialty approach training and work-life balance, but for the sake of keeping this thing readable, let's assume all programs within a particular residency are roughly equal.

Some of these factors may not be intuitive, so let's break them down a little further. What is "sense of resolution"? I envision this as a metric that captures that feeling one gets when flipping over a flash card or figuring out the solution to a riddle. Physicians of all walks spend a great deal of their time making guesses with limited information; the higher a specialty's sense-of resolution score, the more likely you are to actually get a "thumbs-up" or "thumbs-down" at the end of your investigation. I think an exemplar for the lower end of this spectrum would be emergency medicine, whereas one could argue that specialties like pathology or surgery might be nearer the high end.

"Family and societal expectations" is something I threw in there for people with a family lineage full of urologists that might perceive their descendant's choice to pursue pediatrics as a denouncement of their life choices. I think it could also encompass society's assumptions about what type of people belong in different specialties, for example, the intersection of gender and an OB/Gyn residency or the politics surrounding midlevel practitioners encroaching on that specialty's scope of practice. How about geography? Maybe Wyoming is your jam and you just can't picture yourself anywhere else. Well, then Igeo is going to be pretty high, and you'll be vying for one of those 14 family medicine spots available every year in the Cowboy State.

I think you get it. Let's work through an example and see how this equation performs. For the importance values, I'll use a fictitious example for the undecided student. Let's call him "John". Before we begin, a quick request for the reader: please forgive the massive generalizations about various specialties in the next couple of paragraphs. They are the result of equal parts convenience, rationalization, and ignorance.

Now John's most important values are probably |clinic\_time, |resolution, |procedures, |free\_time, and |dark\_rooms. He digs using his hands; he values his free time away from the hospital/clinic; uncertainty is lower on the list, but he'd rather get an answer than be left hanging; dark rooms kind of freak him out; and the clinic isn't exactly his idea of a good

time. Now, let's peruse our specialty chart. It looks like ClinicTime in family medicine is off the charts, so let's go ahead and veto that. Neurology has a higher clinic time and scores on the low end of SenseOfResolution, so we'll scrap that too. Checking out the AmountOfFreeTime column makes him pretty comfortable with dropping all of the surgical specialties. Apart from the little bump from ECTs, I'm not seeing a lot under psychiatry that would scratch that |procedures, itch, so we can throw that out, as well. Same with pathology, allergy/immunology, and medical genetics. And even though radiology is pretty neat, John's negative |dark\_rooms value is going to preclude it as a career choice.

So, where does that leave us? Anesthesiology, emergency medicine, internal medicine, OB/Gyn, pediatrics, and PM&R. So, we ask John about his more minor importance values. He likes working with kids, but |patient\_mix is somewhat important, so I think we can cross out pediatrics. He doesn't have much experience with PM&R, so to the back burner it goes. Other than AmountOfFreeTime, OB/Gyn actually scores pretty well – we'll defer judgement for now. |resolution is making him think hard about canning emergency medicine, but its score is otherwise fairly high. Anesthesiologists usually seem happy with their high Compensation and Procedure values, but it has to get kind of lonely behind that curtain; also, as the specialty that's arguably most affected by midlevel creep, |politics feels like it's becoming a factor. What about the ultimate fallback, internal medicine? It's tough to grade this one since there are so many paths available after residency. John's a non-traditional student though, so that increases the importance of |training\_length. It's becoming clear that we probably won't land on a single answer for "John", but I think the process forced him to delineate what's important to him in his personal and professional life. After objective analysis, It's easier to start applying the "feel" and "fit" concepts with a manageable list of 3-4 specialties instead of 30-40. With this potent knowledge obtained via the neurotic hyper-analyzation known to most medical students, he's sure to figure it all out very soon. Right?

For those of you who are reading this and find yourself alongside me in Camp Indecision, I hope this breakdown has helped you to organize your thoughts. If not, then hopefully you at least found my ramblings entertaining. I will conclude with an attending's piece of advice that has stuck with me throughout this endeavor: "There is no perfect answer." I'm beginning to accept the fact that this decision will not be made as a result of an epiphany, nor from a "precise" distillation of my values with respect to inaccurate but quantified specialty attributes, but rather as a product of much introspection, internal and external deliberation, and a little bit of luck.

## References

<https://freida.ama-assn.org/>

# ZOOM DIET

Balvinder Singh

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Victoria and I shared fish sandwiches from McDonald's in her hospital room the night before she was to begin chemotherapy. She was the traditional picture of a lung cancer diagnosis: presenting to the hospital with a subtle, persistent cough, with workup ultimately revealing malignancy. Beyond this, however, she was anything but traditional. Over the days, in staccatoed conversations in the mornings and evenings, I got to know Victoria. Her life had been hard: a transgender, HIV-positive woman, and now this. She had weathered storms and persevered in ways beyond my experience and comprehension, out of reach of my classical, simple, empathy toolbox. I could, however, appreciate the shock of how a simple symptom may ultimately come to reveal a much more complex and morbid condition. And how hospital food for the better part of a week is not ideal. In part, we bonded over our discussion of foods we enjoyed and that she missed while hospitalized. Removing this from her problem list, via a fried fish sandwich, was the least I could do. Extra mayonnaise for Victoria.

This was my first opportunity to care for an individual either transgender or with HIV. Admittedly, I felt ashamed with my initial discomfort when it came to examining her. As a believer in evidence-based medicine and science, I understood this discomfort was irrational from a biological perspective. I knew this, and yet I have also found that my emotions do not always respect the findings and conclusions established by scientific literature. With time and conversion, this discomfort slowly dissolved. I learned her pronouns. I learned her story. I watched her go home, with a new life course charted, medications and office visits in tow.

So, when the COVID-19 pandemic hit the Midwestern United States just about a month later, and us medical students were ushered out of hospitals and into our desks and onto Zoom, I simultaneously found myself reevaluating who I was as a person. Being a trainee in the medical world was my profession, but with time I began to recognize that my medical knowledge and training was not the only way I could find meaning and contribute to society. In this academic bubble, I had security, health, and the ability to do what I needed to manage this new era of life. "What would Ms. Victoria need?" was a question that slowly became louder. What would the financially and medically vulnerable citizens of my society need during this time? And how could I help address this need? It was a time that required me to step outside of my routine and comfort zone and learn to further hone my role as citizen of a community. A new role for me, but one equally as important to my clinical complement. Ultimately, I found myself volunteering at an organization of homeless shelters across the city, helping to prepare and serve food for their residents. However small and menial that task may have seemed, it gave me newfound senses of purpose and meaning. Much like my existence as a medical student rotating through different services, our roles may be in the periphery, scattered, and often simple, but they serve a purpose and with the goal of helping our team and patient.

This was not how I expected to be spending the end of my third year of medical school and beginning of fourth year. I had a very idealistic and linear plan, with clerkships, board exams, and sub-internships all plotted out. And while I

mourn(ed) the loss of these experiences, COVID gave me an entirely new experience, perspective, and opportunity for introspection that I would never have had otherwise. It gave me the time to reflect on who I was, what satisfied me, and what will sustain and motivate me as a medical provider.

Through Victoria, the residents at the homeless shelter, and our common bond of food, I realized that people are the key ingredient in medicine that energize and satisfy me. I learned to push myself out of my comfort zone, step outside academia, my home for almost two decades now, and use my security, position, stability, and resources to help others in a way I never could as a simple medical student. Thanks to Victoria, a global pandemic, and the fact that food brings even the most unlikely of friends together, I have learned to look for teachers, inspiration, and lessons in all facets of my life, not just in the clinical setting, at my desk, or on Zoom.

PAUSE





# APART, BUT TOGETHER. REALLY?

Hannah Thiry

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I drive around town and see school logo signs in people's yards  
They are for Duluth public schools throughout COVID: "Apart, but Still Together"  
Students have never been more Apart, throughout all of history  
No sports, no proms, no student organizations  
Cyber-bullying has never been so severe and prevalent  
Are we Really Together then?

I went into medicine for the patient care  
I went into medicine for hands-on interactions within a patient's health experience  
I went into medicine to touch problems and concerns, feel edema, listen to heart sounds  
I went into medicine to lend an empathetic hand, caring hug, comforting touch  
COVID has largely changed this  
Not only are we 6-feet Apart, students were removed from learning environments  
Students were Apart from healthcare teams and patients  
Are we Really Together then?

In a time of racial injustice, we are fighting both separateness and Togetherness  
People are working toward Togetherness, but there are misunderstandings  
People's personal experiences never seem to intertwine toward Togetherness  
We are torn Apart because of harsh words, hurt feelings  
We are all A Part of a united nation, but we are feeling very Apart  
Are we Really Together then?

It's election year, yay  
Polarized sides. Is COVID a red elephant or blue donkey?  
Refusal to understand another's perspective  
Refusal to peacefully converse over differences of opinions  
Refusal to even acknowledge another's perspective  
With tendencies to "Call-Out," rather than "Call-In"  
How do we embrace Parts of the diverse nation, when we are Apart from one another?  
Are we Really Together then?

I'm a white woman in medicine; I'm Together with other women in medicine  
I'm Together with the "Lady Liars"

But Apart from non-white women in medicine

I'm Apart from men and non-binary people in medicine

But I'm Together in their solidarity

Am I Apart, but Together?

End.

# TO THOSE WHO CONNECT US

Eric W. Leppink

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There is something profound in the connections we form with other people, a depth of understanding that is difficult to capture in all its details and nuances. That idea is nothing novel, most people understand the poignancy of those connections in some form, even if the manner in which they find, maintain, and enjoy them differs. For some, those connections take the form of a group of people they meet for dinner after a long week, with a loud and lively conversation to help melt away cares and concerns. For others, those connections come from the quiet moments spent with a close friend in between the demands of daily life and living. Despite the differences, the essential function and sentiment can be markedly similar, and fill a central role in the person's life. The connections can be small: a familiar face at the food truck downtown who has the best salsa and a pleasant "Hello!" and wave for free. The connections can be large: the friend who drops everything to see you because one more day will be the last straw. Connections to those around us are so fundamental, so integral, to how many of us live on a daily basis that imagining life without them is difficult to imagine.

The present pandemic has posed a myriad of challenges, from fear for ourselves and loved ones to the toll it has taken on our medical systems. Some of the costs of the pandemic, however, have snuck in more stealthily—an undercurrent of fear, worry, and unsurity. One of these more insidious costs is, at its heart, a simple one: human connectedness. The daily accessibility of connections has become a luxury, found in rare, rushed moments when venturing out of isolation, clutching bottles of hand sanitizer and a fear of those around us. The stark realization that we have taken these connections for granted is a cost of its own, as we are made acutely aware of the things we must no longer do in order to protect ourselves and our communities. The hole left behind is felt most acutely in the abrupt change, but the gnawing awareness lingers. The connections that have been an integral part of daily life end up being the most obvious when stripped away, leaving behind a scramble to figure out how to fill the space. In this pandemic, many things have been lost. It has claimed our loved ones, our sense of security, our trust in those around us, and finally the connections that we have structured our lives around. These losses and their effects will linger far beyond any virus or pandemic. We will start to rebuild as we are able, to renew, to reconnect, to heal, to plan, and so much more.

Amidst all of this loss, there will be many lessons left behind, both logistical and philosophical. Amidst these, however, needs to be gratitude. Not gratitude for the suffering that communities have had to endure, but for the awareness of what there was before that this pandemic has forced upon so many. An awareness of trust. An awareness of support. An awareness of connection. Many of which existed as a reliable and supposedly immutable part of our daily lives. Amidst suffering, sadness, and hardship, we must find gratitude for the things that we have lost, and for an opportunity to share that gratitude if given the chance. It is easy to forget the things we see everyday that form the foundation of how we navigate the world. The small connections that form our lives are fundamental to being human, and the loss of them is not an experience that we should forget. To the ones who help me find my

connections, and reforge them as this pandemic wears on, I will always be grateful, even if I struggle with what to say. I'll keep trying to find the right words, but for now these are the ones I put together for them:

### **“To You”**

We can say it so many ways:

Thanks

Gratitude

Appreciation

Or just a look that has weight

And a smile, closely shared,

But none, it would seem

Can ever say quite enough.

So I hope you can fill in

All the spaces in-between

The words

The looks

The smiles

And feel the illumination

That you have given me.

### **“A Turtle”**

A turtle doesn't need to find his home

He carries it right along with him

A place of belonging that fits him like a glove

And you make me just like the turtle

Maybe less cold-blooded and aquatic

But at home wherever and whenever

Each time that we are together again

# WHAT COVID CAN'T CHANGE

Rebecca Grove

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It had been ten months since I stood on the curb near my house, waiting for the city bus. Route 3 came right by my house and was nearly a straight shot to the hospital where most of my third year clinical rotations had taken place. Although I had caught the bus hundreds of times before, I still had to calm the butterflies in my stomach. The night before, I had set an extra alarm so as not to sleep late and packed extra cash in case my bus pass didn't work. That morning, I sat inside the front door for seven minutes, watching the bus get closer on my Transit app, calculating the perfect moment to abandon the safety of my warm house and make a break for the bus stop.

Game time.

As I walked quickly down the sidewalk, watching the ground to avoid icy patches, I reached behind me to make sure I had packed a face covering. Rifling through a mass of cloth and strings jammed into the side pocket of my backpack, I grabbed a crumpled blue surgical mask. I noted only a few makeup streaks from a previous wear. I'll ask when I get there if they have extras.

I took up my position at the roadside and was joined by a gentleman whom I recognized from a year ago. He always talked to himself while waiting for the bus, usually commenting on his surroundings or recent events, but happily involving anyone else willing to chat. We acknowledged each other with a "good morning" but stayed far apart. He didn't seem in the mood to talk. My eyes settled on his purple rubber gloves, plastic face shield, and N95. I realized he must be a particularly cautious individual. He carried on with his personal dialogue as I fell into a trance. My toes chilled. My warm breath condensed on my face in tiny droplets behind the mask. The bus pulled up at 7:06 am, almost on time, and the two of us climbed aboard. Two plus two equals four passengers, five humans if you count the driver perched in her bucket seat behind a plexiglass shield. I scanned my pass successfully \*sigh of relief\* and looked around to find a spot approximately equidistant from the other bodies on the bus, falling back into the seat as the bus lurched forward.

We passed each bus sign without stopping. I realized no other riders would be joining us that morning. Fine by me; I would arrive with plenty of spare time. Pulling out my phone, I re-read the last email to make sure I hadn't missed important information. Red building, fourth floor, 7:30 am, bring your own device for lecture. Check. I hopped from the bus to the sidewalk and turned toward the hospital. Unsure if my old badge would work, I planned to get in through one of the general public entrances. It was a door I had never actually used, but how complicated could it be? I passed through the sliding doors to find a lone security guard at the desk. Not what I was expecting. "Do I need to complete a COVID screen? I am a medical student." I blurted out. Turns out the screeners were running late, so the security guard waved me past. I didn't even show him my badge. I joined the few employees already

waiting for the elevator, which arrived quickly, but hesitated as three people got on. Was four too many? I have time, may as well wait for the next one.

The second elevator whisked me up to the fourth floor, and a wave of nostalgia washed over me. Busy as ever, I thought, as a surgery team flew by on their way to the OR. I followed the signs to the radiology department where I found the other medical student on rotation with me. We were instructed to wait for the coordinator who would be down shortly. Standard chit-chat ensued and covered everything from the weather to studying for Step exams, all from six feet apart. The coordinator arrived at 7:45 am, somewhat flustered, and hurried us off for orientation.

Apologies were made for the late dissemination of information. The course was evolving, and coordination was difficult these days. The other student didn't have a badge yet but was promised the situation would be resolved soon. We sat through orientation, learning where we could eat and drink, where to tune into virtual lectures, which conferences were in-person, and how to properly disinfect a space before using it or leaving. Before I knew it, the coordinator left and was replaced by a few residents and the attending giving didactics for the day. As we went over cases, I sat quietly soaking it all in. "Who is the future surgeon?" the attending asked, forcing me to abandon my mutism. I tried to describe what I was seeing on the image projected in front of me, floundering until one of the residents came to my aid.

The rest of the day was a blur. More lecture, more details about the schedule, how to page someone properly, how to order the right test, who to contact when we needed something. I blinked and it was 1:30 pm. It felt strange to end rotation in the middle of the day, but these were strange times. The sun came out for just a few moments as I walked back to the bus stop. Alone on the curb, I took off my mask, staring down the road at the approaching bus still blocks away. "Essential trips only" scrolled across its message board. For so many reasons, I wondered if this had really been an essential trip. Before I could think long about it, the bus pulled up, and I slipped the mask back over my face. I considered how life had changed in the past year. So many things were different. Yet this rotation had begun just like every other, with the same nervousness, awkwardness, uncertainty, excitement, and hopes that marked my last four years as a medical student. I guess some things never change.

# MASK. SHIELD. GOWN.

Himal Purani

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**6:30AM** – with the sun still not up and the sky a dark abyss – I step out of my car, put on my face mask and start walking from the parking lot towards my first rotation at Masonic Children’s Hospital. As I course through the frigid morning air and enter the peds inpatient unit, my glasses fog up. I pause, wait for the fog to clear up, adjust my glasses, and retighten the mask around the bridge of my nose. As I walk past the double doors of the peds unit and the colorful backlights, I perk up and make my way towards my unit’s workstation. After settling into my workspace where myself, the other medical student, the intern and the senior resident are all spaced apart as far as we can, we await the sign out from the night team. Post sign out, we discuss the plan for the day and divide up the patient list amongst ourselves. I quickly call and check with the nurses on my patients to see how the night went before starting pre-rounds. As I start gearing up, I mutter to myself...“Mask, shield, glasses. Check. Pen, patient list, pager, unit phone. Check.” By the second week of this rotation, it almost seemed like a new dance that had its own rhythm.

I stopped outside the room of my first patient that morning—a 14 year old male with an eczema flare and possible skin infection. I read the “contact isolation” sign and don yet another layer: the gown. As I get ready to knock and enter the room, I wonder.....*Behind all of this gear, what part of me can the patient truly see? He certainly can’t see the expressions on my face, the color of my skin, nor the badge that states my role on the team. These days, behind all this gear, am I just another set of expressive eyes on his care team. How do I connect with him?*

During these strange and trying times, the COVID pandemic has brought to light so many important and previously overlooked aspects of medicine – simple things like facial expressions (a warm smile), body language, gestures (a warm touch on the shoulder when providing reassurance), and skin color. All these simple yet essential aspects of connecting with patients seemed to be stripped away and hidden under layers of PPE. Although all practiced in good measure for the safety of everyone, I cannot help but wonder: *Where is the human connection behind all the PPE? Where is the medicine that I once knew of—the medicine that relied on your expressions, body language, and gestures? The medicine where the similarities in the color of my patient’s skin and my own skin brought a sense of commonality and understanding of experiences? The medicine where handshakes were the means of introductions and brought with them a certain degree of warmth in the patient-provider relationship?* I yearn for that medicine again – that art of medicine that goes beyond tests, procedures, and medications and the art of the medicine that gets to know the shared humanity of the patient in front of you.

Given the uncertainty of the times we live in today – I’m not quite sure how long this new norm will last or if it’s here to stay. Therefore, as we keep everyone safe behind those masks, shields and gowns, we must also continue to practice the art of medicine. Room-to-room, patient-to-patient, I find myself resorting to new and creative ways of keeping that humanity and connection alive in medicine. I take longer to introduce myself as I say my name and role on the team; I share something I have in common with the patient – whether it be the language we speak, our

favorite color, or our favorite food. I write the names of all the team members on the whiteboard in the patient's room and our treatment plan for the day. Despite being just another set of expressive eyes behind all the PPE gear, I hope these little gestures go a long way in building a connection with our patients. The pandemic has taken its toll on us, but it cannot take away the art of medicine. The medicine that is so profoundly rooted in connection and human interaction – the medicine, that like our bodies, depends on our senses such as sight, sound, and touch.

As I walk out of the patient's room and take off my gear, I reflect on the changes over the past year since the start of the pandemic. Some good, some bad, and some that we have yet to make up our mind on. I see the restrictions on patient/family visitors even on hospice floors, I see loved ones grieving from afar due to restrictions on travel and funeral gatherings, I see the scars and bruises on the faces of overworked, tired healthcare workers as they take off their N95s before returning home. But amongst all of this, I also see the transition to telehealth and the ease of accessing healthcare—especially for the elderly, the immunocompromised, and those from rural areas. I see the reduction in healthcare costs that come with telehealth especially for services that can be provided over the phone or computer without inconveniencing or jeopardizing the patient. I see new platforms of communication and connection in the community. And most importantly, I see a more resilient and stronger community in medicine.

**6:00 PM** – As we finish signing out our patients for the day, I look outside the windows lining the hospital hallway; I see the sun setting in the distant horizon and feel the warmth of the golden rays hitting my skin. I smile as I walk past the double-doors of the peds unit and the colorful backdrop of lights near the entrance. These little touches to the environment are a constant reminder of practicing the art of medicine that not only centers around the patient but their comfort and their connection to the healthcare community.

# WE ARE NOT ALL IN THE SAME BOAT

Jena Velji-Ibrahim

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‘We are not all in the same boat. We are all in the same storm’- Damian Barr

I didn’t think about the pandemic as a storm prior to hearing this poem. I’ve heard people say on multiple occasions that we’re all in the same boat since we all had to make changes to the way we live in 2020. We all had to do our part to physically distance. We all had to make sacrifices. We in fact are not all in the same boat. The pandemic and physical distancing has meant so many different things to different people. For some, working from home was a way to save time and money on commuting. It was a way to reconnect with roommates or immediate family or even nature. It was a vacation. For others, it meant loneliness, uncertainty, job loss and fearing when the next bill would be due.

While listening to this poem, I remembered a patient that I cared for during my Internal Medicine rotation. She had several congenital conditions and with modern medicine, had survived to adulthood. She was developmentally delayed and so her mother was her primary caregiver and medical decision maker. It was clear that she and her mother were very close. Her mother was also very protective of her. Afterall, she knew how to take care of her daughter best. When my patient needed to be hospitalized, per policy, her mother wasn’t allowed to stay with her. While these changes were created to reduce transmission, I started thinking about how dehumanizing they were. I thought about how scary this must have been for my patient and her mother. Her mother was the reason she was still alive. She advocated for her daughter and took care of her daily needs while fighting to make sure she got the care she deserved. I remember thinking about what boat they were in. Was this her first hospitalization since the pandemic began? Did their family get to bond during the time they had together or were they burdened by job insecurity and bills that were piling up? One thing was clear now: their boat was a life raft. They were struggling with new hospital policies, struggling with feelings of frustration and struggling to get quality care. Fortunately, the hospital was able to make an exception so my patient’s mother could be with her during her hospitalization.

While this was a case with a positive outcome, I remembered a story that a resident shared about the bond she forged with a young boy who was receiving chemotherapy. She got to know him and his family overtime. She watched him begin school, make friends and become a big brother. The treatments he was undergoing helped and eventually he was in remission. They were in a boat that offered hope. Unfortunately, the cancer came back and during the pandemic. The boy could only have one family member stay with him at a time. When his mother would spend the night at the hospital, his father would sleep in their car in the parking lot, in case there was an emergency overnight. The boy couldn’t have visitors like he did before. He couldn’t do the things he used to. While the care team, the boy and his family fought as hard as they could, they came to realize that nothing more could be done for him. When they made the decision to stop all treatment and take him off life support only one family member could be there. While the family petitioned for an exception to be made, none was granted. The time came, and his family decided

that his grandfather would be there. The rest of his family had to stay in the lobby. This family's boat was crushed by the storm. Their care team did whatever they could to weather the storm, but it wasn't enough.

While the patients described above were hospitalized and undergoing treatment, they weren't in the same boat. For one an exception could be made, while it couldn't be made for the other. I realized that we aren't in the same boat. The boats that we are in can also change. A week before I wrote this piece, I had a conversation with a neighbor who was describing that she had been "isolating" since March. At the beginning she felt indifferent. The physical distancing wasn't a big deal for her as she wanted to protect herself and people she cared about. During our conversation, she started to cry. Her birthday was in October. Then there was Thanksgiving and Christmas. For all these celebrations, she couldn't be with her family. Her daughter would bring her a food tray, one with the appetizer, one with the main course and one with dessert. For my neighbor, the worst part of it was that her daughter only lived 4 blocks away and yet she couldn't celebrate with her. She couldn't hug her grandchildren. She went from being in one boat to a completely different one filled with sadness and loneliness.

If this was my poem I would write:

We are not all in the same boat. We are all in the same storm.

Our boats are ever-changing. Our experiences are dynamic.

# ISOLATED, NOT ALONE

Jordan Wolf

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Charlie Parr's folksy voice and plucky 12-string slide guitar warbled through my old record player: "You know exactly what's lurking out there, it's all on the news every night." I frowned. Reset the needle. Listened to the song again. Although 'Over the Red Cedar' was released in 2015, the lyrics had a prophetic accuracy for events on and directly thereafter March 11th, 2020. I am, of course, referencing the COVID-19 pandemic and subsequent social upheaval as America continues to enact social distancing measures. Social distancing (while necessary to prevent transmission of this dangerous virus) has taken a psychological toll on Americans laboring through prolonged isolation.

Social isolation has incited or magnified adverse psychological consequences for many Americans. One recent study that measured American wellbeing during quarantine found that the incidence of anxiety is as high as 32% and depression as high as 34%.<sup>1</sup> Among those who reported worsening psychiatric symptoms, low-income individuals were noted to be most at risk.<sup>2</sup> In my own correlative experience on an inpatient telemedicine psychiatric rotation, the data metamorphosize from arbitrary numbers to tangible people, people with unique experiences and struggles. One such patient I encountered was a recent ED admit, on the unit for suicidal ideation. I was tasked with doing the admission H&P, which is a challenge with any reluctant patient but downright formidable when the most soothing bedside manner I could muster was dampened by a grainy Zoom video. Despite the barrier of online communication, I coaxed the necessary information out of the patient. He was a homeless veteran with pre-existing Major Depressive Disorder and PTSD. He had recently lost the tent that served as his home in a fire. He then turned to a local shelter for housing but found it inaccessible due to quarantine restrictions. He could not self-isolate for two weeks because of the social stressors that surround chronic homelessness. In his words, "I had no decision left to make" and was brought to the ED after a failed attempt to jump in front of a train.

My H&P list of questions exhausted, I thanked the man for his time and concluded the interview. I was left to ponder questions only half-formed, new issues that I had never expected to encounter before the COVID-19 quarantine precautions became part of our daily lives. It was obvious the patient was suffering psychological

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1. Salari N, Hosseini-Far A, Jalali R, et al. Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: a systematic review and meta-analysis. *Global Health*. 2020;16(1):57. Published 2020 Jul 6. doi:10.1186/s12992-020-00589-w
  2. Vindegaard N, Benros ME. COVID-19 pandemic and mental health consequences: Systematic review of the current evidence [published online ahead of print, 2020 May 30]. *Brain Behav Immun*. 2020;S0889-1591(20)30954-5. doi:10.1016/j.bbi.2020.05.048

consequences amplified by Covid-19 restrictions . Even my virtual interaction with the patient posed a barrier. It is certainly harder to display empathy through a computer screen. How can physicians provide care for patients, despite this newfound separation? As any good student of medicine would do, I consulted my attending the next day with my concerns.

He thoughtfully considered my request. We began by discussing the staples of any good patient-clinician relationship: teamwork and communication, among others. If fostering a patient relationship was like baking a cake, there was a set amount of ingredients that matched every unique person's needs. Such as: one-part empathy, two-parts listening, a dash of skill. If any ingredient was missing, the cake wouldn't rise. If there was too much of another ingredient, the cake would become misshapen and lumpy, a less-than-ideal form. Unfortunately, it became harder when trying to bake the cake remotely. We had a slimmer margin of error to form meaningful relationships with patients. That made our training even more important. Virtual interactions were a new and unknown ingredient. It shook things up. Out of necessity, physicians pioneered virtual medicine.

The last few months have highlighted the astounding tenacity of physicians. If this pandemic has taught me anything, it's that hardship can bring out the best in people. Collectively, the healthcare community rose to the challenge of the COVID-19 pandemic. We researched our knowledge gaps, adapted to ever-changing policy updates and treated our patients, sometimes at personal expense. We collaborated with one another to develop groundbreaking new treatments in record time. We learned to navigate virtual mediums with our patients while retaining the humanity that blends medicine into art and science. The landscape of medicine has changed dramatically since the pandemic began, but healthcare workers across the world have united to tackle this challenge head on. Now more than ever, I have a newfound respect for the field of medicine and am excited to one day enter my own practice and contribute to the field's resilient legacy.

The music from my beat-up record player faded away, the folk album was complete. In my musing, I hadn't realized it had still been playing. It is true that Americans everywhere are isolated right now. Despite the isolation induced despair that has befallen our nation, there are great people in medicine, armed with science and compassion, working on a cure for both the physical and psychosocial woes of COVID-19. A smile split my lips before I could help it. Yes, we were all isolated. Temporarily, but not forever. That sure as hell didn't mean we were alone.

# COVID-19 AND THE TOLL ON MENTAL ILLNESS, IN THE CONTEXT OF EATING DISORDERS

Hannah Thiry

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## Introduction

Mental illnesses are diseases of disconnection. These illnesses consequently, create barriers, walls, and obstacles between the individual experiencing the illness and their loved ones. The illness itself thrives on solitude, loneliness, privacy, and closed doors. Pandemics are catalysts in creating scenarios that exacerbate illnesses. For example, social support and interactions are limited, a person's daily routine is uprooted, in-person appointments are now virtual, creating a barrier to care. Additionally, gyms and workout facilities are closed, creating a toxic environment of feared weight gain throughout users of social media's home workouts, and 'flattening the curve' of the coronavirus is the top priority, regardless of skyrocketing mental illness relapses.

## Fictional Case Summaries

**Bulimia Nervosa:** Mrs. H is a 26-year-old female with a 13-year history of severe bulimia nervosa, recently in remission. Her exercise is finally healthy, for the appropriate reasons. She limits it to a 1-hour yoga class, rather than the excessive compensation where she would spend hours at the gym 'working off' a 'fear food' she had for lunch. Her 'fear food' is a food group/macronutrient that she tries to avoid because it is particularly provoking to her eating disorder, i.e., carbohydrates, regular pop, cookies, etc. She could not do her 'normal,' safe workouts anymore in an environment of yogis. During the shut-down, she was forced to do extreme home workouts in the seclusion of her home, with no one to check her behavior.

**Binge Eating Disorder, Agoraphobia:** Mr. K is a 32-year-old male with a history of binge eating disorder and agoraphobia. He has a history of extreme self-isolation and binge eating whenever his anxiety is elevated. Part of his recovery is to reconnect with past friends and family through Facebook. Since the pandemic, Facebook has become toxic to him. Facebook is full of posts featuring the feared "Quarantine 15lbs," home workout videos, and tons of dessert and sourdough bread recipes. He has had to unfollow people due to the Quarantine workout challenges, obsession that others had about their body changing, bake-offs, and overall extreme negativity of others. Now he does not go on Facebook, but has continued behaviors that are destructive to his personal recovery.

**Orthorexia, Generalized Anxiety Disorder:** Mr. F is a 44-year-old man with a history of orthorexia and generalized anxiety disorder, well controlled with regular appointments and check-ins with his therapist. His in-person appointments are now virtual due to the pandemic. He lives with his wife and children, parents, and elderly

grandmother in a 2-bedroom home. They have struggled financially for several years. Due to the close quarters of his home, he has not felt safe to openly discuss his condition with his care team, out of fear of being overheard. He has limited cellphone data and no access to the internet, so virtual appointments are very costly for him. Additionally, his orthorexia has been exacerbated due to the temporary closure of restaurants with ‘splurge foods’ and absurd lines for fast-food.

**Anorexia Nervosa:** Miss Z is a 45-year-old female with a history of anorexia nervosa. Her recovery has required laboratory tests and frequent EKGs from her Primary Care Physician to ensure her electrolytes are stable and her anemia has improved. During the pandemic, she has been unable to schedule an appointment at the hospital. Her condition is not ‘essential or life-threatening’. She has also needed to have weigh-ins with her therapist at her treatment center. Now, her lab work has been delayed due to its lack of ‘necessity,’ and she self-reports weigh-in values.

**Binge Eating Disorder, Obsessive Compulsive Disorder:** Ms. M is a 23-year-old female with a history of obsessive compulsive disorder and binge eating disorder. She is a 2nd year medical student studying for her Step 1 board exam. She is now forced to stay at home during the pandemic, rather than going to the school or coffee shops for long days of studying. Leaving home everyday helped remove herself from a toxic home environment, where many of her symptom use had previously occurred- obsessively checking the refrigerator, body checking, and binge episodes. Now she is trapped. Held hostage with her pantries full of food, and permanent bathroom and bedroom mirrors. This home environment may not suffice for a productive study space, which will wreak havoc on her medical education and Step 1 score.

**Body Dysmorphia while in Social Isolation:** Miss H is a 12yo female who has come to discover that her body looks different than her high-school aged sisters. Since the pandemic she has been surrounded by her sisters and their rhetoric about “the perfect body” which the 12 year old feels she does not have. She has heard their discussions, she has seen the looks on their faces as they stare in the mirror and speak harshly about themselves. Surrounded by negative rhetoric of her elder role-models, Miss H. has taken to escaping to the basement bathroom where she wonders if scissors would be an easier solution to shaping herself in her sisters’ image. Can scissors cut off fat?

## Discussion

**Bulimia Nervosa:** Bulimia Nervosa is a form of disordered behavior that includes secretly and uncontrollably bingeing on excessive amounts of food and then using compensatory behavior, such as purging or excessively exercising to rid of the calories (7). On contrary to the ‘quarantine 15lbs’ weight gain, individuals in recovery or recovering from bulimia nervosa are in danger of over exercising on their own when organized and scheduled workout classes are canceled. According to a study in 2020 involving 203 participants, over one third of participants with bulimia nervosa, during the time of the COVID pandemic, reported an increase in their bulimic symptomatology (1). Overall, in patients experiencing bulimia nervosa, “depressive symptoms, general psychopathology, quality of life and therapy...were negatively affected” (1).

**Binge Eating Disorder, Agoraphobia:** Cyberbullying has taken a new lens via social media. Traditionally,

cyberbullying consisted of one person bullying another. However, during the COVID pandemic, cyberbullying has taken the role of self-shaming, diet challenges, group workout videos, and new recipes. These collectively act as triggering foci for those with eating disorders or may even contribute to the primary development of disordered eating for others. Additionally, someone with agoraphobia is ultimately forced into isolation because of the stay-at-home orders, which is the exact opposite of what they should be doing to overcome their phobia. The pandemic has trended to more time spent on social media, away from people, and toward the toxic focus and “objectification of the thin ideal” while online (2). One study quotes an individual who is battling an eating disorder: “Social media mention that mentions weight gain during quarantine are triggering” (3). It is paradoxical how zoom/facetime/google hangout technology has benefited social connectedness, while scrolling social media sites exacerbate the solitude and loneliness for those experiencing an eating disorder.

**Orthorexia, Generalized Anxiety Disorder:** The COVID pandemic is a time of stress, uncertainty, and disconnection. In a report from 2020, survey participants noted an increase in their anxiety from 2019, and overall, there was a greater concern for mental health than physical health during the pandemic (3). Everyone is having to live life in unprecedented ways: work, school, social functions. Those battling destructive mental health behaviors are newly relying on activities that had previously been harmful to recovery, such as cooking from home if their treatment included restaurant menus, limiting trips to the grocery stores if their treatment required fresh produce, or exploring new ways of body movement and physical activity if they had found refuge in the gym (2). People’s treatment teams and group therapies are also forcibly through telehealth technologies. In so many ways, telehealth is extraordinary- except when a video call ironically brings “heightened awareness of bodily self...prompt[ing] self-criticism” and harm to recovery (4). Ridding of on-site weigh-ins also forces someone recovering from an eating disorder to be grossly honest (2), subjecting a threat to their recovery and progress if they’re dishonest to both themselves and therapist, as well as a traumatic affliction due to weight exposure.

**Anorexia Nervosa:** The world has witnessed unforeseeable acts of generosity and sacrifice: food deliveries for healthcare workers, thank-you letters to postal services, teachers devoting unpaid hours to virtual lesson plans, limiting the purchase of toilet-paper. The generosity and sacrifice stretch too far in certain scenarios for those experiencing anorexia nervosa thinking “[they] need to leave food for other people who actually need and deserve to eat and feeling like [they] don’t deserve to eat, as [they are] selfish” (4). A study conducted in Munich, Germany reported that 62% of study participants with anorexia nervosa had increased restrictive behaviors, fears regarding food scarcity, and the inability to comply with their meal plans (3). Healthcare guidelines advise those at high-risk for COVID to take extra precautions. Most people think ‘high-risk populations’ are the elderly, immunocompromised, cancer patients; generally, the “frailty in anorexia nervosa, electrolyte disturbances in bulimia nervosa, and cardiovascular risk in binge eating disorder (2)” are not included. The overall unawareness of eating disorder severity, regardless of a global pandemic, poses further concern for the existence and availability of resources for this ‘high-risk population.’

**Binge Eating Disorder, Obsessive Compulsive Disorder:** The beginning of the COVID pandemic was a time of food scarcity, toilet-paper hoarding, and empty shelves. It has been also a time of furloughs and unemployment. Binge eating can be problematic for families on a budget, accrue unnecessary costs, and further family conflict

and tense emotionality (5), especially if high-risk binge foods have recently been stocked within a home (3). For those with eating disorders who found respite outside of their homes, away from their refrigerators and mirrors, a stay-at-home order did not provide them with safety. Having Obsessive Compulsive Disorder (OCD) and an eating disorder poses a severely devastating combination. A person can obsessively count and recount their budget while finding ways to eliminate their expenses for food (in the case of someone with restrictive eating) because “it saves money” or is “unnecessary.” Interestingly, both eating disorders and OCD are prominent in female healthcare workers (7). During a global pandemic, female healthcare workers have had the “tendency to put others’ needs before their own, negatively affecting their ability to manage their own health (2).”

**Body Dysmorphia while in Social Isolation:** During the pandemic, families have more close contact and interaction with one another than in the last 70 years. Unfortunately for many individuals with eating disorders, there is evidence that “parents... [are the] underlying causation of the illness (8).” This may be for several reasons: parents’ control of available food in the home, parents’ personal exercise and diet habits, or parents’ comparison and comments regarding other siblings in the home. For these reasons, “health professionals tended to perceive the family as trouble... [within treatment of an individual’s eating disorder and, therefore,] parents felt shut out and discouraged from being involved in their child’s care (8).” Alternatively, mental illness therapy and treatment has moved towards including families and friends within the care of a patient, such that the support system is encouraged to be involved with therapeutic sessions, exposure therapies, and appropriately having a role within a person’s recovery journey. “The only way we can actually do well with these girls is via the families (8),” though until family therapy is available again or alternative virtual therapies are implemented, the girls are left with inflicting trauma within their own homes throughout COVID.

## Conclusion

I speak of the Coronavirus’ impact from the lens of eating disorders. However, the virus does not discriminate against any mental illness. The unique scenario of a global pandemic is that all people are affected by the new policies in place, ever-changing broadcasted news, and unfortunate devastation of this illness; not much else in the world has reached this level of impact. People have unique experiences, hardships, and levels of disruption the COVID pandemic has surmounted in their lives. Discussing the toll that COVID has on people suffering from eating disorders is just one conversation among many. Eating disorders are uniquely complex, destructive, and exacerbated in a time of food insecurity, closure of fitness centers, social isolation, and panic buying during a global pandemic. There is a lot of learning yet to do, and it is impossible to accommodate all realms of mental health when deciding the safest public health measures. Public health must pick its battles, but it is very challenging when the battle that is chosen throws a person experiencing an eating disorder on the frontline.

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# A HAND TO HOLD

Madison Ernst

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*DING DING DING!* I fumble around for my phone in the darkness, frantically attempting to turn off my alarm before waking the rest of my sleeping family. The screen lights up. 5:23 AM – the latest possible time I determined I could wake up to make it to the hospital on time. I proceed through my morning routine on auto-pilot, and before I know it, I’m sitting down in the medical student room at the hospital. I look down. 6:30 AM exactly. Perfect timing. I smile to myself and take another swig of my 40 oz coffee (quickly replacing my mask, of course). As with every previous day on my internal medicine rotation, I planned to do a quick chart-check before pre-rounding on the patients I had admitted the previous days. I opened my first chart and began scanning the notes from overnight and noting new labs. Everything was looking up for one of my patients. His labs were improving. Consultants were signing off. All he needed was a discharge plan and he would be up and out of here tomorrow, if not later today. Wonderful!

I clicked out of his chart and opened up the chart of the patient I had admitted the previous evening, around 7 PM. She was an 89-year-old woman who was presenting for evaluation of a week of chest and left arm pain. Her interview and exam the night before had taken longer than my other patient’s – nearly two hours. It was harder, too. This was because, on top of her chief complaint, she was having difficulty controlling her bladder and experiencing frequent episodes of dysuria that triggered nausea and vomiting. With urine cultures pending and empiric antibiotics and bladder anesthetics administered, there was little to do but wait for the medications to kick in. But, until then, every episode of dysuria was torture. She would cry out in pain between dry heaving. She would beg me to give her “something to just end it all already.” Holding the plastic vomit bag in front of her, I remember looking desperately around the empty room for something else I could do to help, something besides a warm hand to hold and reassuring words that I could give her for comfort. There was nothing.

To make matters worse, she was completely alone. Minnesota was experiencing its peak incidence of COVID-19, and guests were no longer allowed in the hospital. There was nothing I could do except wipe the corners of the mouth and hold her hand until the episodes slowed, and she could finally fall asleep. I remember feeling relieved as I tip-toed out of her room to update the nurse and go finish her H&P. After reviewing her newest labs, I attempted to write a plan for the next few days. She had signs of a missed MI, a new UTI, and a likely heart failure exacerbation. I confirmed the plan with the resident and attending and headed home for the night. I hoped that she would be much more comfortable when I saw her in the morning as the UTI resolved.

But when I opened the notes page of her EMR that next morning in the medical student room, something didn’t look right. Instead of the usual 5-10 nursing, lab, and consult notes, there was only one. A death note. As I focused in on those words, it was as if the rest of the world fell away. I could no longer see the coffee on the desk next to the

computer. I could no longer hear the neighboring students chatting about what they watched on TV last night. I clicked on the note.

“Patient went into VT last night during a lab draw. Patient was DNR/DNI. MD paged and pronounced at 9:30 PM.”

*Calm down. She lived a long life. Death is natural. At least it was fast. At least it was painless. Deep breaths.*

I attempted to calm myself down with reassurances and deep breathing. But the emotions just kept coming. First, it was guilt. Did I miss something? Why didn’t I see this coming?

Second, it was sadness. She had been so kind and patient with me. Even when she was in terrible pain, she had never taken her frustration out on me. She did not deserve to die.

What hit me hardest, however, was the thought that maybe I had been the last person to ever hold her hand. This thought brought over a wave of emotions. On the one hand, I felt incredibly privileged. On the other hand, I felt immensely guilty that she had to share her last moments with me instead of being surrounded by her loving sons and many grandchildren. Who was I—a 24-year-old stranger with just a few months of clinical experience— to have such an honor? At what point did I become deserving of the intimacy she had shared with me during those final hours?

Since starting my clinical rotations, I’ve spent a lot of time reflecting on what it means to be a doctor. As I’ve progressed through medical school, I’ve always understood that the degree would come with far more than a pass to prescribe. I knew I would be responsible to provide my patients with evidence-based care and to teach them about their medical conditions in language they can understand. I also knew that medicine would bring a responsibility to advocate for the health and wellbeing of my patients and community both in and outside of the clinic.

But, as I held the hand of the dying woman that afternoon, my role was not to heal. There was no policy for which to advocate. And there certainly wasn’t anything I could teach. In that moment, my most important role as a soon-to-be doctor was simply to be human. The most meaningful care I could provide was the comfort of a warm hand and a humble respect for the dignity of my patient.

The field of medicine is fraught with obstacles that challenge the humanity of its providers. Between the emphasis on exam scores in medical school, the grueling hours of residency, the hierarchical culture that discourages speaking out, and the frustrating politics of hospital business, it often feels as if the healthcare system would prefer if we operated as robots – silently and efficiently. When I think about that afternoon in internal medicine, however, I am reminded that perhaps our most important role as a physician is to remain human.

When we become doctors, the world suddenly grants us an enormous trust. We must remember that such trust—the trust of another’s life— is one of life’s greatest privileges and must be continuously earned. Only by respecting the humanity of our patients can we identify and amend the historical trauma that the medical world has inflicted upon our communities of color. To be deserving of the trust placed in us by our patients from their

first breaths to their final hours, we must first and foremost respect them as people and continuously challenge the policies and practices that strip them of human dignity. And only by respecting and reflecting upon our own humanity can we learn from our errors and develop the authentic connections necessary to fulfil our roles as healers, teachers, and learners.

# ARRIVALS & DEPARTURES

Morgan Turk

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Anyone who knows me could tell you that I'm a sentimental person. A number of seemingly innocuous events have the power to bring tears to my eyes, from television commercials to an especially good meal. As you might guess, I have often felt touched enough to cry during my medical education. On my Ob/Gyn rotation this was especially true as I got to see many vaginal deliveries and cesarean sections. The impact of these momentous arrivals never faded as I expected it might. Instead, each time I felt a fresh stab of wonder from a seemingly inexhaustible source.

One midnight delivery was especially memorable. It was an unplanned c-section due to arrest of labor, and the mother looked apprehensive as we entered the OR. We put up the curtain separating her head from her abdomen, sparing her from the sights to come. Then, the residents began the methodical procedure, cutting and ripping through layer after layer of the abdomen. Most surgeries are performed slowly with precision and care, but c-sections are different. They are quick, saturated with urgency. This father was brave and less pale than the others, peering over the curtain with fascination as we dug deeper and deeper. Suddenly, the uterine incision was announced, and the residents pulled the baby out ceremoniously with a gush of fluid. As usual, tears slipped down into my surgical mask as I watched the mother and father marvel over their first child and cry themselves. What came next, however, was unusual.

As we began the slow job of closing every layer we had just opened, the father began carrying his swaddled baby around the OR, making his rounds. He stopped in front of every person in the room- the surgical staff, the anesthesiologist, the pediatrician, the nurses- to introduce his son to each of us. Before this formal introduction, I hadn't thought about the fact that I was one of the first people to meet these new humans arriving into the world, our paths crossing briefly in their very earliest moments. I met them before their siblings, grandparents, friends, neighbors, teachers, and countless others who will love them throughout their lifetimes. I was also struck with the realization that I had just shared in arguably the biggest day of these young parents' lives.

The next week, I found myself in a similar but entirely different position. I was now on a palliative care rotation; over the span of a weekend I had suddenly moved from witnessing arrivals to witnessing departures. In the throes of a pandemic, the palliative care service had taken on even more tragedy. Over half of our patient census was COVID patients, intubated and sedated. We would peer in the windows of their isolated rooms, though there was not much to observe. Most were prone to assist their desperate lungs, giving us no faces to associate with the names. Some windows had facts written in dry erase marker – “likes classical music,” for example – sent in by families who were desperate that their loved ones be humanized, perhaps in the hope that we would somehow work harder to save them.

While the ICU doctors were busy adjusting ventilator settings and providing other critical care, our job was to talk

with the families who were not allowed to visit the hospital. We were often the single thread connecting them to the world of the hospital, where patient rooms now sat eerily empty of visitors. After listening to my preceptor make a few calls, I was deemed ready to make one myself. My first call was to the family of a patient who had been admitted to the hospital for COVID the night before. He was young, only 55, and he was not doing well. His oxygen saturations remained poor despite maximum ventilator settings and proning. I looked in the medical record and found his emergency contact- his daughter.

I dialed slowly, my heart rate rising, trying to give myself time to think about the right thing to say. This task felt somehow more critical than anything else I had been asked to do in medical school. More consequential even than suturing a wound, determining the scar that will linger on the landscape of the skin for a lifetime. I knew that the effects of my patient's infection also had the power to forever alter him and his family. Before I had time to consider the options, his daughter answered in a voice that immediately revealed anticipation and sadness. It was clear that she and her family had been waiting for this call all day. I pictured them sitting around a wooden table with an old rotary phone in the middle, like a scene in a crime movie from the 1960s. As I updated her on her father's illness, she began to cry, and I heard sobs in the background that she identified as her mom.

She told me about her father. A picture began to form in my head of who my patient was as a person, and each additional detail sharpened my sadness. She explained that her dad was the recipient of a kidney transplant a number of years ago, and that he cherished his new kidney. He did his absolute best to honor the gifted organ by maintaining his health with the utmost care. His current illness would almost be ironic if it didn't feel so profoundly unfair. She translated her mom's words in the background, "My mom says that she doesn't want to live if my dad doesn't live. She says please, please do everything you can." I knew in that moment that nothing I said would sugarcoat the reality into something palatable. I couldn't think of anything but the absolute truth, which was that I was hoping along with her that her dad would pull through. When I hung up, my tears of joy from the week prior were replaced with tears of deep frustration and sadness. They stung more this time. But again, I was struck with the realization that I was accompanying this family through one of the most significant days of their lives. I left the rotation before I could find out what happened to my patient, and I could never bring myself to look at his chart later. I still hope that his immune system put up a fight and he went home to his daughter and wife, able to get many more years out of his new kidney.

As I layed on my couch uncomfortably stuffed with turkey and potatoes during Thanksgiving break, I thought about the startling dichotomy of my November. A father introducing his new baby to the world and a daughter fearing for her father's life. Between the everyday monotonies of medicine – checking lab results, ordering Tylenol, preparing discharge summaries – it is so easy to forget the profound nature of our profession. Every day, we are allowed to walk with our patients through life altering events: the loss of a family member, a sudden disability, remission from a long battle with cancer, the slow toll of chronic illness, a lifesaving surgery, the birth of a child, and countless others. It is life, death, and everything in between. Although we may become accustomed to the weight of that responsibility, I hope that I never lose sight of the privilege and that the source of my wonder remains inexhaustible in my many years ahead as a physician.

# DARK DAYS IN A GLASS HOUSE

Spencer Ilstrup

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I had never been in an ICU wing prior to my surgical rotation. Now, as a newly minted third year medical student, I was entering the surgical ICU for the first time. My first week in this strange new world coincided with the height of the COVID-19 pandemic in Minnesota, and what caught my attention first were those spectacular glass doors.

Up to that point, my medical education had largely been in classrooms, and my imagination had failed to guide me through the glass doors of an ICU room. I still thought of medicine as practiced solely in clinic exam rooms, supported predominantly by otoscopes and ophthalmoscopes. But behind those glass doors beckoned a form of medicine of which I had never dreamt. It was filled with machines that hummed; sedated patients that did not move. Nurses bustled, families huddled, and gravity lingered in the air.

The surgical ICU ward was not operating in a normal state of affairs in November of 2020. In addition to the regular traffic of gunshot wounds and other traumas was an overflow of Covid-19 patients. Even if I wasn't able to see active cases of Covid-19, taking care of patients that had been impacted by the disease was unavoidable. My first ICU patient was an African refugee in his 40s. He had been suffering from a score of diseases that were rare in the Western world (neurocysticercosis, viral hepatitis, and tuberculosis) in addition to a previous stroke. Covid-19 had brought his fragile state of health tumbling down. Now, a couple months out of the COVID infection, his chest x-rays were still whiteout from a superimposed resistant klebsiella infection, and he was sedated, ventilated, and hanging in the grey zone between life and death. His eldest son, the only English speaking adult of the family, communicated on his behalf.

For a week, I served as the conduit for his son's concerns to the medical team. Every morning after night sign out, I would pick out my new patients; gunshot wound, surgical abdomen, necrotizing fasciitis. But I continued to see this static man. There was a continuity to his care that I couldn't bring myself to withdraw from. And each morning, like clockwork, his son would be attentive at the bedside, the sole visitor allowed. The rest of the family, a wife and younger children, were only able to visit their father through Facetime and through descriptions from his eldest son. As I presented the patient each morning to the team of doctors, nurses, pharmacists, and social workers, the son was beside me, taking part in the communication of his father's needs.

Possibly what compelled me to keep seeing this patient were the qualities of his son. He couldn't have been older than twenty, but in the brief moments of small talk we engaged in, I had picked up a few remarkable details of his life. He was a first generation college student. He had learned English in primary school, as it wasn't spoken in his home, and now he was a science major at a nearby college. He worked almost full time, not to help pay for college, but rather to support his family. On top of this, he advocated for his father every day. I felt in awe of this young man for his strength and sense of conviction.

The glass house of the ICU cannot have been easy for him. He was yet another person who had been swept up in the scourge of the pandemic. I so dearly wished that his father's story could feature an element of redemption, a sweeping arc of healing and faith, and the power of modern medicine. But I knew that it could not. The human body can only handle so many insults before it gives in to the pressure of disease. The son who spent his days looking after his father communicated an understanding of this as well. It was only in accordance with his father's wishes that the family kept pushing on. On my sixth and final day in the ICU, he told me that he and his family fought for the small victories, not the larger ones.

Reflecting back, medical school is not what I had once imagined. I can't quite describe what my younger self had pictured, but I know I was brimming with an optimistic naivete. This naivete persisted through my time in didactic education and only now is beginning to wane as I enter into the clinical realm. As much as I have learned about the skills of patient care, I have also been introduced to the blunt realities of aging, pathology, sickness and dying. This is not to say that I am now filled with a sense of pessimism. Quite the opposite. But as I gain experience in hospital medicine, I am learning the virtues of reimagining the goals of care for each patient. I think the reason that this father and son are burned into memory is because they illustrate a lesson that I am just beginning to understand. Mature beyond years, my patient's son taught me that being a good doctor is fighting for the small victories, even when the larger one is out of reach. I owe him—and his father—much more than they owe me.

# DREAMS

Maya Sayarath

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I stood at the edge of the room, my body caught halfway between the sliding glass doors that separated patient from healer. From the computer speakers, the lyrics of Dreams by Fleetwood Mac filled the room: “Now, here you go again. You say, you want your freedom. Well, who am I to keep you down?” The song infallibly reflected the moment occurring at the patient’s bedside.

It was my first day back on the wards since we had been pulled from the clinical environment in response to the COVID-19 pandemic. I feared I had made the wrong decision to make the MICU my first rotation back. But the time between residency applications and now was narrowing and as we all were, I was in a rush to demonstrate my clinical knowledge and skills at an intern level before graduation. So, when it came time to start the rotation, I tied my hair into a ponytail, stocked up on teal blue scrubs and with my N95 mask clipped to my hip, charged forward confidently onto the wards ready and eager to learn.

Richard was 55-years-old, younger than my own parents. He had been a prisoner to his body for 80-plus days, floating between the MICU and general hospital floors. He had been admitted after a biking accident with his son – broken ribs leading to a hemopneumothorax, spinal cord damage resulting in neurological deficits, and sequelae of a complicated hospital course, including pneumonia, countless intubation and extubation trials, PEG tube placements for nutrition. The list could go on. For the majority of his hospitalization, he had been unable to articulate his wishes. The team relied on his two daughters, not more than a year older than me, and his wife to make decisions. Naturally, when asked to read up on Richard, I was terrified of assuming care of this medically and emotionally complex case.

It was only day two of caring for Richard when a care conference was called to update the family and align as a team about next steps. It had become clear to us as a medical team that Richard’s condition was worsening and that he was unable to extubate safely. Even if he was able to breathe on his own, the prognosis was poor. I began to guide the conversation, trying to focus on lacing my words together coherently. It was challenging to speak.

I watched as the faces of his wife and daughters shifted, first challenging that we had tried all the possible treatments and then becoming peaceful as they started to accept the likely outcome of their loved one. His daughter shared that being dependent on others was the exact opposite of what her father would have wanted. He was a man of freedom. Her bravery with her admission that the best step to take for her father was to extubate to compassionate cares, gave confidence to her sister and step-mother to also accept that aggressive interventions were not what Richard would have wanted.

The next day, the plan was to extubate at 11AM. COVID had caused many changes to patient care since the last time I had walked the halls of the hospital, but the toughest for me was the limitation on visitors. Richard had

6 sisters and 1 friend he considered a brother. I mourned with Richard's family that his loved ones would not be present at his bedside. Richard's two daughters and wife sat at his side, holding tightly to his hand. As the extubation process began, Richard's body began to fight in discomfort. The Chaplin asked the family if Richard had a favorite musician. His daughter said, "Fleetwood Mac".

The lyrics that followed brought tears to my eyes. I had never cried in a patient room or been unable to keep a professional demeanor in front of family. Maybe it was that Richard's family structure was so similar to mine or maybe it was the feeling that Richard was telling his family that he was okay with dying through the lyrics that flooded the room. Regardless of the reason, I couldn't hold back my tears. I remember telling myself in that moment, *I hope I never misplace this feeling of empathy for others. I fear the day that I am unable to relate to another human's experience.* It took 30 minutes for Richard's blood pressure to drop into the 40s, for his soul to leave this earth, for him to find his freedom.

As I head into intern year, I reflect on the impact we as physicians have on our patients. We have the privilege to impact patient's lives at deeply personal moments; even guide them in their transition to death. I found this to be particularly true of the MICU, where life and death meet each other every day. Richard's siblings had known him his whole life. And yet, in his final moments of life on earth it was me, someone with only a glimpse into his life, in the room with him and not his family. Somehow I was given this badge of admission, and I wonder if I deserved to be in this position. I question, *did we make the right call as a medical team? What if we just completely altered the outcome of someone's life and were wrong to do so? Would I have made the same choice as Richard's daughters?*

The privilege of a physician runs deep. It allows one access to knowledge and higher education that is, to the general public, inaccessible, securely locked behind large, ivory towers. In the midst of a global pandemic, it grants me access to a vaccine before members of my own community, who have no choice but to go and serve on the frontlines in the form of grocery store clerks, home health aides, schoolteachers. The first step is recognizing the rite of passage into this world of access that my professional path has afforded me. To me, however, the most important step is the one that follows; finding a meaningful way to equalize this access for others, for my communities, and for my patients that I will serve in the most challenging moments.

# TAKING A PAUSE

Sowda Ahmed

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It's 7:10 AM on a warm Friday morning in early July and I am on the second week of my acting internship in internal medicine. I have finally gotten the hang of the rotation, and am now comfortable with my daily routine. My morning tasks include seeing 4 patients, including Mrs. X, who has been my patient since the first day. I make my way to the 6th floor of the hospital, always taking the stairs since exercise isn't easy to come by these days. As soon as I get to the nurse's station, I receive multiple urgent pages about two of my patients. By the time I return the pages and finish updating my senior resident, it is already 7:30 AM. That leaves me with only about 7 minutes to spend with each patient. I don't get to Mrs. X's room until 7:52 AM, 5 minutes before I have to head back downstairs for rounds. I put my gown, gloves, facemask and shield on before entering the room. Mrs. X has just finished receiving her medications and is facing the window as the sun fills the room with brightness. I go about my regular questioning and physical exam, but this doesn't feel quite right today. Mrs. X seems more reserved. I ask if there is anything else I can do for her this morning, but she quietly shakes her head no. I check the time and realize I am a few minutes late for rounds. After thanking Mrs. X for her time, I make my way back down to the workroom, still thinking about the encounter. Something was bothering her, but I couldn't quite figure out what.

The time is now 2:30 PM. Rounds took a bit longer, noon report ended later than usual, and I still had to call several consultants and four notes to complete. As I began sifting through my checklist, I couldn't get Mrs. X's out of my mind. After checking in with all the consultants, I decide to visit Mrs. X. Even though today was exceptionally busy, I knew I had to revisit Mrs. X. After getting to her room, I sat down on the windowsill and asked her about her day. She immediately began sobbing. She went on to explain how today was difficult because it was her husband's birthday, and this was the first year in over 30 years she didn't spend the day with him. At this point, Mrs. X has spent over 40 days in the hospital and for most of that time no visitors were allowed due to the COVID-19 pandemic. Over the next 45 minutes, I learned more about Mrs. X's husband and their marriage. She remarked that he will be making the over 10 hour drive up to come see her next week since they aren't from the area, and visitors are finally going to be allowed starting next Monday. We think of some birthday gift ideas for him, and ways they can celebrate when he visits. Even though Mrs. X was medically stable today, there was another component that was affecting her wellbeing, and this was equally important to understand as one of her providers.

The time is now 4:15 PM. The long call team is asking if we are ready to sign out our patients. I tell them that I still have my notes to write but will update the sign out sheet first. I don't get out of the hospital until closer to 6 PM, but I have never been more satisfied with a workday. I walk out of the hospital with the sun still beaming, but I continue to think about Mrs. X and how she is unable to spend time with her husband today on his birthday.

I was reminded of this counter after reading "Stopping by the Woods on a Snowy Evening" by Robert Frost during a recent literature and medicine session. We reflected on the importance of taking pauses in life, and how that is a

rare occurrence for many in medicine. The medical community strives for increasing efficiency which inadvertently results in spending less time with patients. I thought back to that Friday afternoon with Mrs X and how it was important for me to spend that time with her. There are many non-medical and personal factors that can influence a patient's wellbeing, and I was able to truly understand this after caring for Mrs. X for several weeks. She taught me that as healthcare providers, the power of pausing from all the tasks; sign outs, notes, scheduling follow-ups to visit and really talk with a patient helps us be present for them and ourselves.

I will use this as a guiding principle as I embark on this transition from student to doctor in just a few months. Knowing that even on my busy and difficult days, my patients need me to take that pause to be with them. I have the privilege of being able to walk out of the hospital every day, but my patients do not.

# PAUSE

Monica Olivier

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I sat down at the computer and began reading about my assigned patients, as is expected after morning hand-off in the inpatient pediatric wards. My first patient was a ten-year-old boy with a history of tethered cord syndrome, which incited a multitude of other neurological sequelae, who was status post his second corrective spinal surgery. While delving into his chart and reading past notes, I could not help but to be overcome by sadness and heartache. This boy and his family seemed like they pretty much lived within the hospital. So many procedures, so many subspecialists involved in his care, so many admissions and prolonged inpatient stays.

As we were not allowed to see patients prior to rounds due to Covid-19 restrictions, I prepared my oral presentation for morning rounds as best as I could— complete with overnight events, vitals and recent labs, and my assessment and plan which mainly focused on post-operative pain control and close coordination with physical therapy in order to assess patient mobility. In my head I wondered what the patient looked like, and if or how his attitude and morale were affected by numerous hospital stays.

Rounding seemed to pass slowly as I anxiously waited to practice family-centered rounds in front of a patient and family members I had never met before. Finally, we reached his room in the PICU. I knocked on the door and walked in, the leader in a train of other students, nurses, residents, and attendings.

“Hi,” I exclaimed, genuinely excited, “It’s great to meet you!”

One by one the medical team introduced themselves. I then took a deep breath and began my presentation. I was just about to report that the patient had been afebrile overnight when I was suddenly interrupted.

“I’m going to call you Smiley,” said a small voice.

I looked up and realized it was the patient that was speaking to me. Forgetting all about my presentation, I crouched by his bed.

“Smiley, huh?”, I teased.

With a little grin on his face, he continued, “Well, so many people come in here every day, and I can’t remember everyone’s name. So yup, you are Smiley!”

“Well silly, you can’t even see my smile with this mask I have on,” I said.

He shrugged and said nonchalantly, “I can tell you are smiling by your eyes.”

My heart swelled, and I felt my throat begin to tighten as I tried to maintain my composure.

“Well aren’t you just the biggest sweetheart?”, I said, looking towards his mom.

She nodded.

I think about this interaction a lot. It is one that I truly believe will always remain ingrained in my mind. I had entered the room half expecting a defeated child, visibly beaten down by yet another hospital visit that kept him from living the life of a “normal” ten-year-old. Instead I encountered a cheeky, little fellow with a heart of gold that in many ways turned out to be the most intelligent person in the room.

Upon leaving the PICU, a poem by Robert Frost titled “Stopping by Woods on a Snowy Evening” crept into my mind. When dissected, the poem speaks of a man traveling in a rush, with many matters to attend to. This man takes a moment to pause, despite a fast track world of progress urging him to do otherwise. He pauses with such intent that he is able to hear the sound of falling snowflakes.

As a future pediatrician, I sincerely believe that us adults, us doctors, have much to learn from children. This child, who so endearingly nicknamed me “Smiley”, had grown up spending most of his life in the hustle and bustle hospital lifestyle, and yet he took a moment to pause and recognize kindness and good intention. In doing so, he urged me to pause, abandon my rigid patient presentation, and do the same.

As a fourth-year medical student 6 months away from embarking into the structured chaos that is residency, I now realize how important it is to pause. Medical school was hard and busy. Residency will be harder and busier. What I fear most, is that while engulfed in this world of “hard and busy” I will forget why I was called to medicine, and more specifically pediatrics, in the first place. The remedy to this affliction is quite simply, an intentional pause. We must pause and treat ourselves with grace during a day that seems tumultuous and invincible. We must pause to celebrate the small wins. We must pause to reflect on children that unknowingly make our hearts burst, unknowingly reinvigorate our spirits, with something as simple as a nickname.

# RELAX

Curtis Bashore

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It was 3 AM.

The green telemetry line flashed across the monitor. Though I knew better, I could not help but stare and attempt to analyze it, vigilant to detect even the slightest irregularity. The patient, my newborn son, lay sleeping peacefully, blissfully unaware of the context and circumstances leading up to his arrival. I sat there in the still silence, utterly helpless.

For the past three and a half years of my life, I had spent countless hours in lectures, simulations, seeing patients, reading textbooks and doing seemingly infinite amounts of practice questions. All of this aimed towards my goals of becoming a pediatrician, dedicated to using my acquired knowledge to improve the health of children. However, I don't think another ten or twenty years of training would have changed how I felt at that time.

Early that evening, the obstetrician came into the room and informed us that our son would have to be in the NICU for antibiotics after my wife spiked a fever during labor. Just a couple weeks into the COVID-19 pandemic, the hospital was fairly strict on its procedures for visiting patients. This meant my wife and I could only visit my son separately. After he was born he had some brief but joyous skin to skin time with his mother and was brought over to the warmer to be assessed by the NICU staff. After this, he was wrapped in a blanket, placed in a bassinet, and wheeled off to the NICU. I briefly glanced back at my wife, tired from her tremendous feat of labor, and she gave me the nod that said she was okay. I quickly tailed the NICU team, keeping a close eye on my son. Racing through the hospital hallways – definitely an unusual first few moments—he stopped crying and began to look around, likely taken aback by the newfound motion. His joyride was interrupted on arrival to the curtained NICU room where he was transferred to another warmer. With the efficiency of a NASCAR pit crew, nurses and techs began hooking him up to the monitors. EKG leads on his chest. A blood pressure cuff on his left leg, pulse oximeter on his right toe. An IV was inserted in his left arm which was wrapped in an arm board. The curiosity he displayed during the bassinet ride was quickly replaced by a soft newborn cry of obvious annoyance, as it became readily apparent to my son that this was far cry from the sheltered darkness of the womb. I couldn't help but recall times throughout my rotations when family members mentioned the challenges of seeing their loved one hooked up to machines – having just met my son I was already struggling with these feelings. Having finished their tasks, the staff slowly exited the room leaving me alone with my son, who had decided to tolerate the recent disruptions and return to sleep. I sat there in the silence, this new, living breathing human in my arms who was so vulnerable and made me feel as if everything else around me had paused. He was born at the onset of a global pandemic, in a world full of uncertainty and yet all of that was put on hold in that NICU room as my life completely changed.

The hours passed into the next day. My wife and I continued to alternate shifts with my son, desperately waiting

for the moment when we would be able to have the whole family together. That morning, the NP came in and delivered additional news – with continued hypoglycemia and hypothermia, my son would have to continue to stay until he met certain thresholds. Throughout the day we watched updates closely and grew more desperate, hoping he could make it to us soon. That afternoon, with growing anticipation and desperation, I was holding him in my arms, silently pleading to him. As we sat there, his eyelids fluttered open. Staring at me for the first time in a while were his deep brown eyes. Running on a few hours of sleep and flurry of emotions, I couldn't help but be drawn in. Despite my level of exhaustion, I could tell he was looking at me with a look that said,

“Relax dad, I got this”

I will never forget that moment.

A few hours later, he met all of his required thresholds, and was able to spend the rest of the hospital stay in our room. We discharged from the hospital the next day, our lives forever changed. That newborn boy is now nine months old at time of writing, his days of mostly blissful sleep replaced with relentless curiosity and a constant desire to climb up our bookshelves. The ignorant bliss of the first time I held him in my arms has largely been replaced by the chaos of residency applications, interviews, graduation, current events, and life stresses. Sometimes though, I get lucky – before a nap or bedtime when he starts to be overtaken by fatigue, he will look up at me and remind my often-stressed self of the same message he sent me in that NICU room.

*Relax dad, I got this.*

# CATS ON ZOOM AND THE BIG UGLY TRUTH

Sam Lorentz

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Living in the time of layers of crises, I'm left wondering if cats on Zoom are a rebellious act and sign of a culture shift in medicine. Perhaps this is a shift in the balance between the professional and the personal, the perfect and the messy, the comfortable and the uncomfortable.

Being personal has an important place in health care, especially in family medicine where I spent most of my time. However, professionalism certainly has remained the focus and established norm. For me, this professional distance has placed my colleagues, residents, and mentors on a sort of mysterious and admirable pedestal, untouchable and nearly perfect. I was afraid this was a level of perfection I could never achieve. Still, I noticed the professional separation between myself and my patients and it was exciting to grow in my professional identity. I felt myself fit into my white coat more easily and walk around with some confidence with a stethoscope around my neck, no longer just a strange prop.

Then came COVID-19, and suddenly I was home in my pajamas scrambling to find a corner of my home that would be a suitable background for the onslaught of Zoom meetings ahead. My partner and I would compare schedules for who was going to need to be on audio because our shared space was so small that it would be hard to avoid hearing the other person in the background. I would just be getting off of a phone call with a crying loved one who wanted to talk about COVID19 conspiracy theories. Quickly turning on my camera for my Zoom meeting, I'm sure my lack of sleep was written on my face as I smiled, "hello, how is everyone?" I never realized what a loaded question that could be.

Many emails came about the importance of wellness and encouraging students to speak up when they were overwhelmed. In the past there were real or perceived obstacles in admitting to poor mental health, a temporary need for rest, a need to be late on a deadline, or an excuse to say "no" to something in the endless stream of responsibilities. Suddenly struggle was expected and part of casual conversation. Many meetings were held about ways forward, well-intentioned, but often too eager to skip to tying off loose ends and finding the teachable moment in chaos. Fellow students would share intimate struggles in the chat on Zoom. Silently, we held pain together without further motive around seeming impressive or resilient.

Other norms changed too. Zoom lectures with doctors in casual business attire would be interrupted by their half-naked toddlers. Quickly the doctor would rush to mute themselves and then gracefully announce that it was a good time to take a five-minute break. There was no loss in admiration nor trust in their abilities, but instead I found myself more comfortable and engaged in the rest of their lesson.

The all-mighty structure of medical education was once an immovable mountain. With the new authority of a pandemic, I turn to see Step 1 and other requirements kneeling to announce their farewells. I forgot that the system

was built by regular people, perhaps when they were at home in their pajamas or with their half-naked toddlers. The system was not carved from stone by the force of nature as it had always appeared to me. Seeing behind this veil did not make the structure seem more flimsy, but more adaptable and trustworthy. Not a mountain, but a machine that we have all built and maintained and still have the tools to change.

Around the same time, a different sort of vulnerability was shown in the midst of the Black Lives Matter uprisings. Anger, normally an ugly-appearing emotion, became honesty. Political discussion became moral rather than unprofessional and irrelevant. Residents that I had been intimidated by as I practiced my oral presentation skills were now people I was partnered with in working on issues that were bigger than either of us. We were people hurting and spending their weekend holding trash bags for each other as we cleaned up glass along a burnt street.

Racism in healthcare was once a luxurious hour or so discussion or perhaps an extracurricular interest. It transformed to be one of our most pressing responsibilities. Racism and white supremacy showed itself in the bones of medicine as we analyzed the growing body count. My own colleague defaced the memorial. I think of the years my peers of color discussed race with me only to now watch the shock on white faces. As the owner of a shocked, white face this was a time to lean into every bit of discomfort I could and to not hide this journey through a glorified and idealistic lens. Now was not the time to be perfect, now was the time to embrace the ugly and uncomfortable and messy.

The importance of professionalism is not diminished. However, vulnerability is also key to my own confidence and identity in health care. While we will clean-up, organize, and systematize our approach to this new world, I wonder what messiness should remain. What will be swept back under the rug or, with all the best of intentions, be set on a display shelf to collect dust and call no attention to itself or what it once stood for. I wonder what the future has to say about the professionalism of cats on Zoom.



EXHALATION



# NOT READY

Anonymous

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Pandemic time  
Stands still and flies  
First a few  
Now many lives

Yesterday  
A summer walk Now today  
A winter lock

Two days ago  
I had proposed  
Now today  
All venues closed

Three days ago  
I dined indoors  
Now my country  
Decomposed

Four days ago  
I started school  
Now today  
The real work looms

Five days ago  
Without a care  
Now today  
I'm worse for wear

Six days ago  
The leaders knew  
Now the leaders  
Are children too

One week ago

I pledged an oath One week from now  
Just a ghost

Pandemic time  
Stands still and flies

I am not ready  
To care for lives

# A PIECE OF THEIR OWN HEART

Anna Wojcicki

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On the night of August 21, 2020, a young, white man was caught spraying black paint over the eyes of the George Floyd memorial at the intersection of 38th St. and Chicago Ave. Pictures were posted across social media, asking anyone with information to contact community activists. It was not long before he was identified as a 4th year student at the University of Minnesota Medical School.

A few days after the news of his actions became public, a meme began to circulate on social media. Yellow text on a background of maroon, emblematic of the University of Minnesota's colors, declared that "you can't be a doctor and a racist except... if you attend the University of Minnesota School of Medicine #takehiswhitecoat" (@projectdiversifymedicine). The post was meant to be provocative. I thought it missed the point.

In a lecture on Structural Racism in Health Care during Becoming a Doctor week, an important reminder was given to us- "Do not assume that medical training has inoculated you from practicing racism, in fact the opposite may be true." Becoming a physician does not automatically grant an individual moral superiority or purity. And it certainly does not give one immunity from the influence of a racist society. And how could it? Medicine does not exist in a vacuum. There is nothing inherently anti-racist about anatomy lab and biochemistry. Western medicine is an American institution, like all other American institutions, meant to advantage white people through historical, cultural, and interpersonal dynamics. Let us not forget the American Medical Association's historical practice of barring black doctors from membership, delegitimizing black medical schools and supporting segregationist policies (Baker et al., 2008). While the @projectdiversifymedicine post was met with a chorus of "I can't believe it" and "this is so shocking", one user wrote:

*"That first slide is confusing to me... because I know many, many racist doctors. The anti-racist doctors are the exception in my opinion. (@minamooshie)"*

Medical school admissions committees are the gatekeepers of our profession. When the lack of diversity in medicine is highlighted, the spotlight often falls on the medical school admissions process. How to increase the number of underrepresented students at our medical school. How to create a process that mirrors our utopic vision of America's future doctors. The idea that somehow the rigorous process of medical admissions will select out racist individuals is naive at best, damaging at worst. One might argue that, in fact, medical school admissions are designed, whether consciously or unconsciously, to benefit those with privilege, resources and institutional power. Who else has seen the studies correlating socioeconomic status to standardized test scores?

I knew the student who defaced the George Floyd memorial. He was one of 12 in my faculty advising group. During the first two years of medical school we spent hundreds of hours together, learning how to take a patient history and complete a physical exam. We even sat in a conference room on the 6th floor of the Phillips Wangenstein Building

on a wintery day in 2018 and discussed the social construction of race. What will be unsettling to some is this- he was not extraordinary. He did not stand out. In all of our discussions he never gave any hint that he was a closet bigot. A more meticulous admissions process would not have picked him out. There were no red flags. He was decidedly average- a white, Christian male, from a family of great socioeconomic means. He was a prototypical medical student.

The idea that “you can’t be a doctor and racist expect...” gives people comfort. It furthers a narrative that the way to prevent damage to communities of color is by identifying and weeding out bad actors. It creates separation. I would never, so therefore I am not. Like all things in life, it is not that simple. How do you prevent other students like him if they are not waving confederate flags and spewing hate at every opportunity?

We expect extraordinary acts from institutions that were created to uphold the status quo. Despite the talk about commitment to underserved populations, diversity and equity, medicine has historically been an institution for the elite, for the people who have always benefited from power in America. The process of becoming a doctor is a series of checkpoints, each one an opportunity to narrow the field. You can trace the disparities back to before an individual was born. Medical students from the top 5% of households (based on income) are overrepresented not just compared to the U.S. population but students at all U.S. colleges (Youngclaus & Roskovensky, 2018). Medical school admissions committees know this and yet they continue to value ivy league education over state schools and HBCUs, high test scores and experiences not available to students from lesser means.

Undoing the legacy of medicine in America requires a departure from the way things have always been done, but this reality would be painful for those who have enjoyed the benefits of our current institutions. Upending the status quo would mean for many turning away their brothers, children, and friends. I am reminded of a quote from *The Gulag Archipelago* by Aleksandr Solzhenitsyn (Solzhenitsyn, 1974-78). Reflecting on the Soviet forced labor camps he writes:

*“If only it were all so simple! If only there were evil people somewhere insidiously committing evil deeds, and it were necessary only to separate them from the rest of us and destroy them. But the line dividing good and evil cuts through the heart of every human being. And who is willing to destroy a piece of his own heart?”*

If the medical field is truly committed to lasting change, it will need to do more than appoint chief diversity officers and mandate social justice training. We had lectures and discussions on race in our curriculum, one of our peers still defaced the George Floyd memorial. A process which produces significant change will not be easy.

For many it will feel like they are destroying a piece of their own heart.

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# DARK SKIN IN A WHITE COAT

Dwayne Gibbs

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During Becoming A Doctor week, I, like many of my classmates, found myself distracted by the attempted coup at the White House. Watching the angry shouting and cursing of Right-wing rioters and Trump supporters, who were convinced that the recent election was rigged, triggered feelings of pain and sadness within me. I noticed camouflage, body armor, neo-Nazi and Proud Boys shirts, Confederate and U.S. flags waved together, and the noose and gallows. These were not distant images of fringe groups or extremists; they were all-too-familiar symbols of intimidation, subjugation, and terrorism toward black and brown bodies. I thought to myself, “this is America, this is who we are”.

What unfolded at our nation’s capital on January 6, 2021 reminded me how afraid I am as a black man living in this country. The fear I have is not distant or metaphorical; it’s real and paralyzing. I fear for my life when I hear about another confrontation with police ending in a black brother or sister’s death. I fear for my fiancé (a black woman), my unborn children, my family, and my close friends. I also fear for my future patients, especially those who look like me and whose skin color is darker than mine. White supremacy and racism are ingrained in the fabric of our nation – in our politics, education, government, law, housing, economics, and environment.

With MLK day approaching, I think about Martin Luther King Jr.’s rebuke of the healthcare system in the U.S.: “Of all forms of inequality, injustice in health is the most inhumane because it often results in death”. If MLK were alive today, I wonder what he would say about the present state of our nation and the huge health disparities that still exist between races. Black people have the highest rates of obesity, hypertension, diabetes, and hyperlipidemia, but also the worst outcomes. Learning these statistics about your people as a medical student is humbling.

I am 1 of 6 black males in a class of approximately 175 medical students at the Twin Cities campus. In 2019-2020 black males comprised 2.9% of medical school enrollment in the U.S., compared to the 3.1% enrolled in 1978-1979. Underrepresentation of black men is just as bad in medical leadership and academia. According to the U.S. medical school physician faculty data, 3.6% of full-time faculty in 2018 were African American or Black, while 5.5% were Hispanic, Latino, or of Spanish origin. Navigating the largely white medical environment while feeling like you have to represent your people every single day is isolating and beyond stressful. As if proving my value and fighting against internal and external stereotypes weren’t difficult enough, I am constantly reminded that I represent a medical institution that has historically experimented on, neglected, and harmed people of color. It pains me to see how the COVID-19 pandemic has only highlighted our nation’s sin towards its black and brown citizens.

I will never forget one of the patients I cared for while doing my surgery rotation. She was a woman with an extensive medical history that included obesity, diabetes, and colon cancer. She underwent an exploratory laparotomy due to a cecal perforation and intra-abdominal infection. I remember presenting her case the next

morning and then walking into her room along with the rest of the surgery team. She was a black woman who wore a silk bonnet just like my grandmother. As we stood over her and examined her large incision and multiple drains, I couldn't help but notice the power dynamic that existed between her and our surgical team. She was not only a patient of lower education and socioeconomic status compared to our group of highly educated physicians and physician trainees, but also a black woman at the mercy of an all-white team of physicians. I remember her saying that the pain was unbearable and that she needed stronger pain medication. My chief kindly and empathetically reassured her that her pain would improve and that the first few days were "the worst". Our team walked out of the room, one by one. I was the last to leave. When I turned around, I saw her place her hand over her mouth and signal that she was about to vomit. After grabbing her a blue vomit bag and a box of tissue paper, I excused myself and left the room. In that moment, I felt terrible and helpless. I wanted to tell her that I held her small intestines in my hand to prevent them from falling off the table, as if they were the single most important thing in the world to me. I wanted to tell her about the anchoring stitches we carefully put in-place to secure her G-tube and diverting loop ileostomy. More importantly, I wanted to tell her that I saw her humanity and valued our shared identity as two black folks in a very white world.

In the past several weeks of rotating in psychiatry, pediatrics, and surgery, I have seen just how underrepresented we are in medicine. I have yet to cross paths with a black physician or surgeon in the hospital. As a third-year medical student, I realize that a physician's empathy and connection to their patient can heavily influence their clinical decision-making and quality of care. That extra blood test or imaging study, that extra moment talking with a patient or their loved ones, that extra glance at a lab result, medication regimen, or wound care plan can make all the difference between a patient's optimal recovery or unneeded suffering. When I rotated at a pediatric hospital in Minneapolis, I saw first-hand how institutional racism and prejudice delayed the diagnosis of critical subglottic stenosis in a 3-month-old African American infant with existing laryngomalacia. Her parents' pleas for the doctors to fix their baby's stridor and hypoxemia were repeatedly ignored by medical providers. It took several admissions to the hospital before ENT was finally consulted.

I'm thankful that the faculty and administration of my medical school are speaking out against racism and pledging to make major changes to "our curriculum, our leadership, our recruitment strategies, and our healthcare practices", according to Dr. Tolar. However, to be honest, I'm cautiously optimistic. Promises, initiatives, and listening circles must turn into concrete action. Representation in medicine needs to be better than what it was 40 years ago. Recruiting more physicians who are racially, ethnically, and culturally representative of our patient populations will improve the quality of our care and the health outcomes of the people we serve. I don't want a black woman in pain to feel isolated or unheard. I don't want the desperate pleas of young black parents to be disregarded. That is why it's so important for me to be where I am. This is our America and there is still more work to be done.

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# THE IRONY OF THE IVORY TOWER

Kristine Nachbor

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Everyone is welcomed into the ivory tower. You are welcomed by smiling faces. Smiling faces that nod at the list. A list you must complete before you enter the door. But, of course, you are welcome here.

And on that list, you will see clearly the seven requirements [1]. Oh, you are surprised? Requirements are necessary to enter the ivory tower. They are quite clearly listed. All the seven requirements, and there are a few fees. Fees for those requirements. Fees for applying to schools. Fees for flying. Fee for lodging. And, once you have paid the fees, then we need your fee to hold your place to attend. Everyone pays to enter the ivory tower [2]. But, of course, you are welcome here.

Let's just say that you are like me. That you take some time off between undergraduate school and more university. Somehow, you are able to put all the fees down. When you enter the ivory tower, you will look around and see that the ivory on the outside is representative of the inner diversity. Our MCAT scores matter, they must be around 512. We also care about GPAs because we do not want anything less than 3.6 around. These might seem limiting, but we want limited life experience too; we are looking for those only a year or two out of school [3]. But, of course, you are welcome here.

Now, you might wonder, why should you care. The ivory tower is open for all those who fight to get there. Unfortunately, that is where you are wrong. For you see, I have many friends who are not here since the lists and fees are so long. Fees, lists and scores prevent my friends from entering. These items close doors. But, of course, you are welcome here.

Yet, the data shows that our monolithic ivory tower is no different than those across the country. The history of racism in the medical system is a problem with roots over 2,500-years-old and continues due to racial stereotypes perpetuated by many famous physicians, scientists and scholars [4]. Despite the initiation of the ACA, Black Americans are still less likely than their white counterparts to be covered by health insurance [5] and these economic factors alongside systemic racism within our medical system led to stark health outcomes between Black and White Americans [6]. Our recruitment and awareness of health disparities over the five-years has not correlated with an increased number of Black men in medicine; Black males entering medicine has only increased by 0.3% to a grand total of 2.9% [7]. That means there are more spots for the 512 MCAT, 3.6 GPA students who can pay to enter. So next time you decide to fight for inequity, I beg you to question how you are currently benefiting from lack of diversity. But, of course, you are welcome here.

The ivory tower is ironic in its color and the welcome signs it posts. We have an opportunity to change the narrative. Next time, pause, before you say, "all are welcome here." Is it realistic to say you are welcome and then give a conditional list? Is this list and fees feasible for everybody? What about that 3.0 GPA who barely got by but now

wants to be a MD? Change can happen but it needs to start with actions that show our words. To welcome all means to truly value more than grades, to see them as baselines, instead of great escalades. If we truly value the big and small, the life experiences, then we can say with truth in each word that, all are welcome into the University of Minnesota Medical School.

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# ON EMPATHY

Catherine "Cat" Bledsoe

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We closed the final intersession of medical school last week. Described and designed as an opportunity for collective diastole in an education and career demanding systole, we gathered, virtually of course, for one more filling. My screen teemed with a sea of black rectangles and red microphone icons as one of the deans welcomed us and introduced the results of our class's wellness survey. Beginning our first semester, the school periodically invited us to participate in "pulse surveys" to gauge our interest, experience, and empathy. Empathy tends to decline throughout medical training, he explained to us, before proudly announcing that despite this, our class had managed to maintain a high level of empathy throughout our four years. In fact, our survey showed we were more empathetic than we were this time last year!

My first reaction was, how? We'd all endured the standard trials and tribulations of exams and clinical rotations in medical school. In the last year, we'd also had our third- and fourth-year schedules interrupted, navigated a global pandemic, and served as guinea pigs for the inaugural virtual residency interview season. On top of that, we as a class reckoned with the aftermath of George Floyd's murder in Minneapolis and the subsequent defacing of a memorial by one of our former classmates. Reflecting on 2020, I could certainly note how I'd enriched my coveted store of resilience, but I wasn't sure if or how it correlated with my empathy.

Empathy was something that had been on my mind a lot lately. Throughout the course of the preceding eleven months, I'd watched doctors and public health leaders attempt to persuade and then plead for people to stay home, to wear a mask, to believe what they were telling them. Too many people were getting sick, being hospitalized, dying. Others were overworked. Surely everyone could relate to at least one of those ideas or experiences. The pushback against and sabotage of that messaging frustrated me, and I struggled to connect to the position of these counter-arguments. This feeling returned as news of an attempted siege of the Capitol broke shortly after the dean's congratulations.

I kept the live stream of D.C. open on my screen as the afternoon workshops played on. I remember wondering then, and in the days since, where things would go from here. How do you navigate, and hopefully bridge, an empathy gap? Particularly for industries where empathy is both protective and fiduciary, was empathy something that could be taught or trained?

Curious, I fired up the Google machine to see what I could find. There were plenty of hits: popular science, self help books, and even some scholarly research populated the results. There were myriad theories of the mind, but

operationalization of these abstract, psycho-social concepts proved complicated.<sup>1 2 3</sup> Nonetheless, I poured over paragraphs detailing the neural circuits revealed by fMRI studies. Several papers proposed the concept of mirror neurons, cells that allow us to learn by watching and then imitating others.<sup>4</sup> Others suggested that while there were common empathic pathways, “[i]t’s what you do with that information that determines whether it’s empathy or not.” A psychopath might demonstrate the same neural flashes in response to the same painful images but experience glee instead of distress.”<sup>5</sup>

The more I read, the more complicated the idea of empathy became and the more I wondered what I actually understood of it. I could name experiences and describe the feeling of relating or connecting with another’s mood or encounter, but even now, forming a succinct explanation involves trails of ellipses. Indeed, other bewildered scientists have developed webbed lexicons to deconstruct the idea of empathy in an effort to get back to basics, or a curricular basis. For example, empathy came in many flavors, including a cognitive version, which must exist in the absence of emotional empathy secondary to inherent biases based on racial, ethnic, religious, or other differences.<sup>6</sup>

I spent a day combing some of the contemporary literature for greater understanding, but I found myself returning to a New York Times article in between studies. The article detailed the travels of a molecular biologist turned cognitive neuroscientist interested in conflict resolution. He’d worked with and studied cultural conflicts in Ireland and Eastern Europe. In his experience, resolution efforts tended to focus on correcting differences or voids in empathy. In other words, peace would come after increasing empathy on both sides of the conflict. However, he proposed a different theory. For example, to him, “suicide bombers tend to be characterized by, if anything, very high levels of empathy.”<sup>5</sup> It was the shape, nature, and allegiance of the actor and his or her empathy that mattered. Depending on a person’s identity and relation to another, the mind could generate an “empathy gap,” muting the paths discovered and alluded to by neuroimaging. In this way, “[i]ncreasing empathy might be great at improving prosocial behavior among individuals, but if a program succeeded in boosting an individual’s empathy for his or her own group...it might actually increase hostility toward the enemy.”<sup>5</sup> In the end, affiliation and empathy for others were inversely related.

Perhaps that is the moral of 2020. In a year in which “normal” was turned over and shaken, we clung tightly to

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the things we understood and “knew” — our identities and our communities. Through all of this, we third—and now fourth-year—medical students have floated in nominative limbo. We were pulled from clinical rotations at a time of year when most of us were finally hitting our stride and feeling useful. We decided what kind of doctors we would be by reflecting on that limited experience and how we hoped to affect the future of patient care, based on the disparities that had been underscored by a summer of protest and unrest. We’re emerging from a kaleidoscope of formative experiences as “real doctors” and the only ones who really understand what that means are the classmates who’ve shot out of the wormhole with us.

# STUTTER-FREE

Monica Olivier

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I am a nervous and anxious person at baseline. I am going to go ahead and blame this on the wonderful world of genetics, seeing as my mother, as well as my two sisters, suffer from the same affliction. What does that mean, however, a third-year medical student transitioning to life on the wards? It means constant fear of criticism. It means stuttering and fumbling through oral presentations while feeling the skin on your face slowly turn red. It means perpetual thoughts of inadequacy. “Okay, here it is, the moment where everyone finally realizes I’m here not because of competency, but because of sheer dumb luck.” These thoughts weigh me down, not always, but sadly, enough to be bothersome. However, what saddens me above all is the fact that a few students, many students, most students, feel the same. There is a wide range of “traits” that could aggravate this vulnerable position even further, and sink a student deeper into this chaotic whirlpool of emotions. For me, it is being a woman.

I was in the OR, standing behind the blue drape. I remember curiously asking the anesthesiologist about the “dance” between sedation, and, simply put- not killing the patient as heart rate, blood pressure, and ventilation are monitored with ceaseless attentiveness. It came as no surprise when later on that day I learned that the motto for anesthesia is “vigilance”. After a while, my interest wandered past the machines and over the drape. It was an off-pump CABG surgery. I marveled at how the surgeon coordinated the placement of sutures with the beating of the heart. I squinted my eyes to see the surgical needle so delicate and thin that it seemed invisible. I looked at the sternum, split in two, clinging on to its rib appendages and remembered thinking– how in the world are they going to put this thing back together? It was then, lost in my own thoughts, that I heard a male voice say, “Who are you?”

“Oh, me?” I asked, looking to see if there was someone else standing behind me.

“Yeah, you.” said the surgeon impatiently.

“Oh.” I peeped, my voice a bit shaky. “I’m Monica, the medical student. I’m with the anesthesia team this wee–.”

“What are you interested in?” asked the surgeon briskly, cutting me off.

“I’m interested in pediatrics.” I replied.

“Of course you are. You’re a girl in med school,” he said, not even bothering to look at me. Playing my part as the dutiful medical student, I said nothing. The surgery proceeded without complications.

I was angry. I was angry for two specific reasons. One, was the way the surgeon so overtly discounted pediatrics as a noteworthy specialty. Here was yet another physician buying into inter-specialty stereotypes that often bombard us as medical students. He was not the first to rag on pediatrics, and he will not be the last. Two, was the way he said “girl”, sneering almost. His comment labeled me. It infantilized me. I was no child, and I had worked just as hard as

my male colleagues to get to this very stage of my life. Male colleagues, who I find it hard to imagine would ever be referred to as “boys”.

This is just one example of a microaggression I have encountered as a female medical student. Rather than wallow in self-pity, waiting for the culture of medicine to change, I decided to prepare accordingly and approach these comments (which were bound to occur again) analytically and systematically. As a medical student, and quite frankly, a care team member positioned on the bottom of the hierarchy, I had to be ready.

First, I wrote down possible responses to these comments. Cordial responses of course, but also ones that supported my role as a student doctor. Second, I practiced saying these comments, out loud or in the mirror to assure a smooth delivery. As a student with painful anxiety, who stutters during oral presentations, who feels perpetually inadequate, I knew this step was especially important. And lastly, I vowed to support fellow medical students who would one day encounter similar microaggressions. Often it is much easier for other people in the room to step in and diffuse an uncomfortable situation, especially when emotions are high. We must advocate for our fellow students, and other care team members in general, who possibly, like myself, feel perpetually inadequate.

I know that my self-doubt will not last forever. It will slowly crumble over a period of years as my knowledge and clinical skills strengthen. However, I do not think this lack of confidence will ever fade altogether, and microaggressions will unquestionably always be present. However, I now have tools to use when side comments unhinge me internally, while externally, my face remains stoic and my mouth remains closed. Maybe future Monica will have the strength to look that surgeon in the eye and say, “Yes, pediatrics is a field where women physicians predominate at the moment. However, in my class there are many brilliant, accomplished women AND men who have decided to pursue it.”

I have a funny feeling that as time passes, this statement will be stutter free.

# FAILURE IN MEDICAL SCHOOL IS NOT DETERMINANT

Germán L. Vélez Reyes

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Undoubtedly, the first two years of medical school were a life-defining experience. During the first year I realized how naïve and unprepared I was. It is hard to know what to do or how to prepare for something until you have the opportunity to actually experience it. Back in 2011, I decided to leave the comfort of home and an institution where my family had received their education for 3 generations. This definitely took me off my feet and left me “on my own”.

Studying habits have drastically changed from my undergraduate experience, to my graduate and medical education. When I came to medical school, after completing a 2-year postgraduate program at MIT, I became used to solving problems on the spot or in exams. MIT is known for its different way of teaching and open-ended questions, instead of relying on multiple choice testing. On the other hand, during the first two years of Medical School we focus more on the “knowing” rather than the “solving”. On top of that, we have a massive amount of material to understand, memorize and master. Open-ended questions and long answers are not the way to go when assessing large amounts of materials in hundreds of students.

So, as you may have been guessing, I struggled a little, resulting in me failing the Cardiology and Respiratory Medicine final exam in year 2 of medical school. Not surprisingly, it happened again later with 2 SHELF exams. It is hard to understand how this happened and how it continued. I know that there were some distractions in my life, such as working more at my local church and trying to juggle too many things at a time such as relationships and family. That previous summer my grandfather passed away from metastatic pancreatic cancer. The influence he had in my life is unmeasurable.

Some changes were made initially during my second year, so that this wouldn't happen again and so that I had the knowledge and tools in hand to help my patients. Nonetheless, it did happen again. In order to be better at memorizing and retaining the material, I had to reach out to people, to gather recommendations and tips on how to improve my memorization ability. This played a lot with my pride. I had never had to reach out for help in such a way, and I wasn't sure how to do it. Up to this point, I was able to easily manage schoolwork and life, successfully gathering excellent grades. Secondly, I had to identify better places to study that had little to no distractions, and other techniques, such as using mnemonics. Thirdly, I had to get rid of my performance-driven attitude and put into perspective the material: now I was not studying to acquire knowledge and do “well”; now people's lives were at stake.

As an MD/PhD student my program has been pivotal in supporting me. My time as a member of the University of Minnesota MSTP community has been life-transforming. I have experienced life and training in a way that I never

expected. Long hours studying while keeping up with my family and faith was challenging. Making friends with my new colleagues in medical school was rewarding, and I enjoyed networking and interacting with researchers at the University. Training undergraduate students in the laboratory helped me solidify my interest in academic medicine. I have become more compassionate and patient during this time. The process of obtaining my PhD taught me the importance of setting both short- and long-term goals, prioritization, time management, and perseverance. Love found me and with it I found my true self. I have been humbled by the process. I realized that the goal of learning medicine is not to get a high score on a test, but rather to become the best physician-scientist I can for the benefit of my patients.

As it is important to have knowledge, it is also important to look out for one's well being. For me it was pivotal to remain physically and spiritually active. I also treasured even more the value of family, friends, colleagues, etc. Loving people gave me an outlet to let my pride down. It made me vulnerable in a way I never expected. This, in it of itself, is transmitted to patients as well. When we are not doing well from a physical, spiritual, and emotional perspective this becomes self-evident to both our colleagues and patients. We are more likely to rush and skip important steps and/or details. We may become detached from a patient's situation altogether.

As I applied to residency programs and prepared to interview, I was enthused to go through this process. I encourage my colleagues who have gone through the same or are afraid of failing to continue persevering. Now life has given me another opportunity to grow: I was not able to MATCH this year into an ENT program. At the time of writing this I am still processing this, as this puts a hold on my future plans from a career and financial perspective. I feel disappointed. Although I was prepared, I was hoping for the best and to move forward given my overall preparation. This year, over 20% of MATCH applicants did not place into a residency program. As medical education continues to shift towards a patient-centered approach (rather than score-based approach), plus new positions open across specialties, we will see positive changes in diversity and recruiting of talented physicians. Grades and scores do not make a physician. One should study as much as possible and strive for excellence in both knowledge and practice. Always strive for the best and to do well. At times, we will encounter obstacles and difficulties. Look for help. Talk to your peers and mentors. It takes a village to train a physician. We are not alone in this.

# BECOMING JADED

Nuwan Pathagamage

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I guess it happens to everyone, I thought to myself as I sat in the cold molded plastic chair belonging to the Labor and Delivery office. The night shift, weary from late night deliveries and magnesium checks had just come in to give morning sign-off. The morning attending ran through the door, scrubs askew and pager in hand, and asked for a quick update. “The woman with dizygotic dichorionic twins is doing well, the mother who just gave birth is resting soundly . . . and then there is the patient in Room 1.” A synchronous harmonic groan protruded from the oral cavities of nearly everyone in the room.

I was always confused by the term jaded. For many years, I thought of jade as a cultural term for a durable beautiful gemstone used by craftsmen of an ancient world. It was only later in life, more specifically while completing this essay, that I came to learn that this word’s origin is a description of an overworked horse.

The idea that medical students evolve from open minded, kindhearted learners into blunted hardened residents is not something new. Article after article has spoken on this phenomenon. The fact that satirical blogs address this issue should erase any doubt of its legitimacy. In sessions on navigating challenging patient encounters, we discussed matching our patient’s emotional level and validating their feelings. This all sounds well and good, but if you asked me what I saw on the wards, it was sometimes something else altogether. Instead of true empathy, what I saw was tolerance with a dash of apathy. A subtle, “I’m so sorry,” delivered while eyes continued to be glued to the computer screen. A couple of head nods masking glances up to the clock on the wall. A few generalized niceties after a knock on the door followed by a barrage of negativity in corridors and in offices once the door had clicked shut.

If I told my first-year self that these sorts of things happened, he would be shocked. He would throw up his arms and demand change. However, to third year me, it made sense. No longer was medical care as simple as filling bubble C over D. No longer were patients without knowledge, opinion, opposition, penury and real tangible audible suffering. Combined with long hours, piling debt, a broken healthcare system and the fear of litigation... it’s no wonder medical students lose empathy. How could we not?

I guess it happens to everyone, I thought as I caught myself joining the groaning chorus. The patient in Room 1 had been, to use a word we are taught not to use in notes, difficult. She was more than a week post-op with poor pain control issues, a high DVT risk, and a strong desire not to move from the supine position she laid in. I saw this patient when she came in and I noticed sympathy decrease as her problem list lengthened. Sign-off to sign-off, her reputation and infamy grew. Soon providers who had never seen this patient joined in on the muttering and complaints when her name arose in end of shift conversations. I even remember one provider questioning her capability to take care of the child she recently bore.

This is the part of the story where I tell you about how I saw her over the course a week and I built a rapport. I

mention how it began with simple facial reignment but then transitioned into back and forth questioning about heritage, family and the people we have at home. It incorporates a point of alliance, a story of her addiction to heroin and a proud reveal that she quit cold turkey five years ago prior to the birth of her first child.

However, the reality is that I had ended up a groaner too.

I truly believe that all providers start as extremely sensible, kind and compassionate people. Yet, like a young thoroughbred foal, we get saddled and bridled and adjusted to human weight. Over time our speed slows, our stamina wanes and a scary reality develops where we are destined to break down. However, I cannot think this way. I have to believe that we can become more than an overworked horse.

# AN UNFORTUNATE ERROR IN THE IR SUITE

Connor Dedeker

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When one thinks of success in medicine, they likely think of it in terms of objective data: cure rates, length of hospital stays, number of post-operative complications, and more. A good surgeon is measured by his or her ability to remove a gallbladder through a few small incisions without causing bleeding or infection. A competent family physician is measured by average HgA1c levels among his diabetic patients. And a hospitalist is measured by how well he or she can handle acute sickness in the hospital leading to safe and prompt discharges. What if, however, this train of thinking misses the mark of true success? What if real medical success is based more on the subjective than on the objective? On the satisfaction of the patient, rather than just the numbers? Now, I must admit, going too far down this road could be dangerous. I am not suggesting that we forego data and replace it solely with a patient's feelings; this would be detrimental to the patient, provider, and overall health-care system. What I am proposing, however, is more of a balance between the data and the visceral experience of a patient when they are in the hospital, clinic, or surgery center. In other words, I think we as medical professionals have a tendency to overlook the human aspect of medicine. While not easy to measure on a piece of paper, a purposeful attention to humanity is something that I believe can make a world of difference in the lives of our patients.

It was a routine visit to the ER. The patient in room 15 was presenting with back pain that started months ago and was now acutely worsening. He was an older gentleman who, to be frank, clearly did not like the hospital (or doctors, for that matter). He was an army veteran with morbid obesity and evidence of multiple previously treated ventral hernias scattered across his abdomen. I offered to take the lead on his care, and he was admitted to the floor shortly after our first encounter. Over the next few days, my team and I worked to form a plan to evaluate and treat his back pain. We drew labs, ordered radiographs, and performed daily physical examinations. We carried out our respective duties as his primary providers. However, there was a persistent, intangible wall between the patient and our team. We were cordial and respectful, of course, but the all-important aspects of authentic human connection and rapport were lacking. He did not seem to like or trust us, and we struggled to break that barrier down. As a result, the humanity portion of his care was suffering.

Radiographs suggested osteomyelitis of the lumbar spine, and a trip to the IR suite for a bone biopsy was scheduled. Coordinating an IR procedure can be quite difficult, and we were feeling extremely proud to have made a strong enough case to get our patient a slot. We expectantly waited for the results, frequently refreshing his chart in Epic. Alas, a note from the IR physician was uploaded, which read, "biopsy not performed due to patient discomfort and respiratory distress with prone positioning." This was the last thing we wanted, and expected, to see. Even worse, we were all aware of how the ensuing conversation with our patient would go. Unsurprisingly, we were met with anger, yelling, a few swear words, and a promise that our patient would never step foot in a hospital again.

I deserved every bit of contempt directed my way. Why did I not see this coming? Why did I not think to reach

out to IR about the potential complications of an awake procedure considering our patient's unique abdominal condition and underlying COPD? Why didn't I consult anesthesia? These questions bounced around my mind as I swallowed the reality that I failed to provide him the care he deserved.

No matter how standoff-ish this patient might have been, it was my responsibility to immerse myself in his care to the same extent that I did with the kind lady next door who thanked me wholeheartedly every time I saw her. To be completely honest, the potential for discomfort and outright inability to tolerate the biopsy did not even cross my mind, and I can only attribute that to my lack of personal connection with this patient. He was the "patient on the 7th floor who hates doctors", and I let that perception get to me. As a result, my lack of attention caused him pain, humiliation, and hurt. In addition, the paucity of communication from my behalf led to asynchronous care between our team and our interventional radiology colleagues, as I had critical information about the patient that I did not share, which left them unprepared and without the necessary resources to successfully carry out their job.

There is hope, however. We were able to make amends with the patient and he underwent a biopsy under general anesthesia the following day. I apologized and promised him that I would learn from the situation in order to better serve my future patients.

The potential ramifications of making an authentic connection with patients span farther than simply making someone feel comfortable while in the hospital; it leads to better medical care. It pushes us to go the extra step, to think about the little things, to cross every T and dot every I. And in a world where success is measured by data, numbers, and statistics, I would like to propose that maybe it is the crossing of T's and the dotting of I's that are the true determinants of medical success.

# THE TRANSFORMATIVE POWER OF REFLECTION

Molly Lindstrom

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As a medical student nearing the end of my pre-residency training, I have come to realize a few principles that I would like to use to build the foundation of my practice. I want to be a physician who can truly listen to my patients and learn more about the context of their presentations. I want to truly understand my patients' goals so that I can best help them achieve these goals, during and especially after their hospitalization or clinic visit. I want to work together with my patients in a balanced partnership, where we can come to an agreement on a plan that is best for their needs. However, these principles were challenged when I admitted a certain patient during my time on the internal medicine service.

I was tasked with the final admission for my team one evening. I had scanned through this patient's ED note and was already anticipating a problematic visit: he was a young heroin user. Previous attempts with suboxone had been unsuccessful. He had come to our hospital and was being admitted to our team with a fever and chest pain. He had just been diagnosed with cholecystitis at another hospital two days ago, but had suddenly left against medical advice and without adequate treatment for his condition because of, according to the notes from that visit, "inadequate pain control."

Upon further workup, we discovered he had developed a right-sided pneumonia, a large parapneumonic effusion, and *Staphylococcus aureus* bacteremia. He was started on IV antibiotics to treat his infection. However, given his daily IV heroin use and the risks for serious complications from his *Staphylococcus* bacteremia, the best option for him was to complete a full four- to six-week course of antibiotics as an inpatient. With his pattern of abruptly leaving during his prior hospitalizations against medical advice, we attempted to plan a backup oral course for him just in case this stay would meet a similar outcome given the serious nature of his infection.

While getting our patient to agree to this antibiotic plan, especially the prolonged inpatient stay, was challenging, the most difficult task my team and I faced was controlling his pain. He had a very real reason to have pain and to require a more aggressive pain management plan compared to the average patient on our service but, with his history of years of daily heroin use, we were hesitant to provide a more aggressive regimen that included more than low-dose opioid medications and clonidine to help with his pain and withdrawal. Yet, for any other patient without a history of substance abuse, we would not hesitate to increase opioid dosing or frequency until their pain was adequately addressed. I found this dichotomy particularly unsettling, as it seemed to be based heavily on whether or not one decided to trust their patient, rather than an objective analysis of a patient's needs.

Despite how much I detested it, I found myself struggling to avoid embracing this dichotomy. Each day when I reassessed my patient, he would tell me his pain was not controlled and would ask if he could have more pain

medication. And each day, I couldn't help but question if what he was telling me was the truth. He generally appeared comfortable, and he did not seem to be in the excruciating pain he described to me. I couldn't help but wonder: was he asking for more pain medication because he was craving opioids since he didn't have his heroin? I was discouraged by how quickly I came to doubt my patient. I knew that, in almost any other situation, my team and I would have been more aggressive in changing his pain regimen. However, because of his history, we struggled to find a medication regimen to better manage his pain, the war between practicing good opioid stewardship and meeting our patient's alleged needs making it nearly impossible to feel confident about any of our decisions.

Unfortunately, our patient tired of our hesitation to increase his opioid medications and ultimately left against medical advice, only days into his antibiotic course. Even though we had spent so much time discussing the complications of inadequately treating his infection, he left so quickly that we couldn't even provide him with oral antibiotics, our carefully crafted backup plan now also a failure. This triggered a storm of emotions for me, mostly anger and frustration. I was frustrated that my team and I had spent so many hours revising his care plan only to produce no improvement in his outcome. I was frustrated by the limitations of the healthcare system that prevented us from providing other safe alternative options for his care. I was angry that our patient's addiction to heroin suppressed his ability to adequately assess the risks of insufficient treatment of his infection.

What angered me the most was how this patient had forced me to confront so many challenges to my personal beliefs about how I want to practice medicine. I want to be able to trust the patients under my care, but I could never allow myself to really believe what he had told me about the severity of his pain and his need for more pain medication. I tried to consider his case within the context of his presentation, accepting his difficult history of heroin addiction and homelessness, however I could not authentically understand or empathize with the challenges he faced and how they affected his decisions during his hospital stay. I tried but eventually could not effectively partner with him in directing his care, as I was unwilling to compromise in giving him more opioid medications due to a strong belief that the risks outweighed the benefits for him. And I was even more upset that his departure, due to "inadequate pain control" as in so many of his previous encounters with the healthcare system, seemed to validate the doubts I had about my patient's reports of pain and the hesitancy I felt to collaborate with him on his pain plan.

However, after reflecting on this encounter and reminding myself to assume that he may have only been able to tolerate so much, I was able to appreciate much more about this experience. Spending about one week in the hospital, completing only one-sixth of the recommended IV antibiotic therapy, may have been the best he could manage given his opioid addiction, his cravings, and his previously questionable history with the healthcare system. After all, in most of his recent hospitalizations, he had left after only one to two days at most. My team and I had been able to convince him to stay for almost a week of IV antibiotics, and while not an ideal course, this likely helped to prevent some severe outcomes. We had also educated his partner and family about the importance of completing antibiotic treatment, and we were confident that they would be vigilant and prioritize his safety. We had also discussed the options of substance use treatment, and he had actually agreed to consider addiction treatment in the future. Though these points had initially seemed insignificant, I realized that my team and I had made major strides in his care, especially considering his complicated history with the healthcare system. I was then able to recall

this experience without experiencing anger or frustration. Instead, assuming that he had been doing the best that he could manage, I only regretted that we weren't able to do more for him. Though we had been able to treat his infection with IV antibiotics for nearly a week, we had only managed to provide him basic addiction medicine counseling, offering treatment some time in the future. I couldn't help thinking that, if we had been able to find him inpatient addiction treatment options immediately, and had he been agreeable, that we may have been able to make an even more significant difference in his life. However, I also recognized that we, too, as a team had simply done the best that we could, offering him the best care that we had available.

When reflecting on this experience through this therapeutic lens, I am more energized to make a difference in my patients' lives. Assuming my patients are doing the best that they can will help me maintain a more positive and encouraging outlook on my practice, even in the most difficult situations. An angry patient is not someone who is antagonizing me or the healthcare system, but simply a person who is struggling to deal with everything that has been thrown their way; one challenging interaction does not define them. A patient who leaves against medical advice is not someone who doesn't care about their medical condition or treatment plan, but one who has endured all the changes to their routine that they can handle at that moment; they may be able to do even better with their next encounter with the healthcare system if I can make their experience with me as supportive and positive an experience as possible. Even if it is difficult to maintain this outlook in the moment during a patient encounter, using the assumption that everyone is doing their best to reflect upon a negative experience or on an outcome that was unsatisfactory, such as a patient leaving against medical advice or one refusing life-altering interventions, can help alleviate lingering regrets or remorse and instead transform the experience into a more positive one. This assumption will allow me to encounter difficult patient care situations while reaffirming, instead of challenging, the principles I have chosen for the foundation of my future practice, while also allowing me to remain engaged in providing the best care possible for my patients.

# FORGET THE PLOT POINTS: A RECKONING WITH READING

Kevin Butcher

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I had an unsettling realization during my fourth year of medical school. I had forgotten how to read. Not only had I lost track of the how – the mechanics of running my line of sight smoothly past each word, putting them together in my mind to make sense of a sentence – but I had similarly lost the why. Why read? Or rather, why do we as individuals, we as humanity, read? My partner can finish a stack of books in a month; she can finish a book in a day if it is dreary enough. And yet, I find no similar impulse to read within myself, nor do I find any of the same joy.

Throughout medical school, the simple thought of nonmedical reading made me feel overwhelmed. I felt the dread of yet another task to complete and the guilt of not being able to engage life outside of medicine. Most reading in medical school is mandated (or at least feels that way). Each day I was responsible for hundreds and hundreds of unique PowerPoint slides. Imagine collections of cold, pale backgrounds splashed with nauseating walls of monotonous black text. On a good day maybe there would be some poorly formatted clip art or an image with resolution so poor it made me wonder if I needed new glasses. Single slides would amass into a lecture, and lectures would stack together to form a typical day, and the weeks would arrive punctually, and ultimately, I felt as though I were blindly wading into an ocean of knowledge, tasked with counting each and every water molecule, only to realize I had forgotten to account for the rain. How could I? You would forget how to read too.

Feeling obligated to read is itself a troublesome relationship to have with literary works. I recall cleaning out my boyhood room after graduating high school and coming across Seuss's *Oh the Places You'll Go*. A feeling of nostalgia and inspiration coursed through me. Where *will* I go? The book carried the same words as it always had, yet my shifting stage in life brought new meaning. I was receptive. For the sake of delineation with a risk of overdramatization, consider someone hearing this book as they are wrongfully sentenced to life in prison. Or consider the birds reciting tales of exploration and odyssey to Prometheus as they pick at his liver. In these cases, there is no choice of receptivity. There is no purpose or intentionality, only dire irony. The reader has not signed the tacit agreement to welcome new worlds. Whereas words under normal circumstances would combine to form a powerful and moving creation, much like Chuck Close would compose *Frank* (1969) one small grid at a time, a mind coerced to appreciate art will only observe the superficial contents, devoid of depth, devoid of substantial meaning. (*Frank* may be glossed over as a neat photograph.)

Meaning is in the details. Yet reading as a medical student is about efficiency, about ignoring superfluous details. For example, it may not be necessary to read the wall of text when the last sentence is most likely to be tested. That is to say, can I count the most relevant water molecules, the ones in my immediate surroundings, so that I can at least float and avoid drowning? This likely constitutes the bare minimum of what qualifies as reading. The enjoyment of

swimming does not come from the avoidance of drowning, and similarly the enjoyment of reading does not come from only grasping the main plot points. The enjoyment of swimming is in the experience – the waterline that rises and falls on the chest, the clouds above that either welcome or warn, the chilling expanse of the lunar sea floor, the reefs teeming with color, the mystery that lies beneath. Similarly, the enjoyment of reading is in letting the details wash over you.

The style of reading that I adopted in medical school would yield a summary of Tolkien's *The Lord of the Rings* trilogy that clocks in at a cool one or two pages. Some sort of small prototypical human obtains an invisibility ring that is the root of all evil. He and some friends decide to destroy it in a volcano. On their journey, they are chased by some ghosts and goblins, the trees are alive with the sound of smashing things, the wizard decides he looks better in white, and the friends realize two breakfasts are better than one. The home team wins a lot of battles before properly destroying the ring, they catch a direct flight home, and the main character decides to celebrate by sailing around the world.

I expect it is clear how ridiculous that all sounds. For meaning is in the details, not the plot points. Meaning is in the human experience of adventure, in the emotional highs and lows that we relate to. Meaning is in the warmth of enduring friendship and the heartbreak of loss. Meaning comes from taking the time to reflect, not from memorizing the plotline. The *fact* of Frodo's success is meaningless without knowing how his intimate friendship with Sam underscored the world's survival. Forget the plot points.

The question becomes, does it *matter* that medical students are forgetting how to read, or more cynically, that medical students are mandated to forget as a means of survival. Afterall, our patients would rather have calculated, informed logicians than sappy dreamers, right? I do wonder if this deeply flawed thinking is responsible for the societal perceptions that physicians are arrogant, self-assured, poor listeners. I unequivocally feel that it *does* matter that we are forgetting to read. As we internalize our shortcuts to obtain information, I fear the consequences spill over into our patient encounters. I fear that we instinctively continue our hunt for plot points, missing key details that would reveal three-dimensional narratives from one-dimensional facts.

As much as technology has advanced since human inception, I question to what degree our emotions have evolved. That is to say, is the *experience* of being human that much different than it was thousands of years ago? Do we experience the emotions portrayed by Homer more or less vividly than he? I would say, "no." Even if there is a semblance of truth to a universality of human existence across time, the outcome would identify literature as the great uniter – untold volumes of joy, suffering, hope, and despair.

I am reminded of one of Sigmund Freud's famous disciples, Carl Jung, and his thoughts on the "collective unconscious." This is the idea that all humans share an unconscious ancestry, a collection of memories deep within us that explains how archetypes seemingly transcend culture. Assuming there is even a mild degree of truth to this, narratives become our expression, exploration, and perpetuation of innate commonalities. In this way, literature is a conduit of emotion, a thread which loops our hearts and ushers them intimately into the minds of our peers in humanity.

Assuming this to be true, it is intuitive that physicians are in danger of losing touch with the common threads of humanity. There is understanding that comes with reading. We not only gain insight into how other minds think, but are provoked to overlay our experiences onto the lives of others. We recall personal life events that match the emotional experience of a fictional character, thus contemplating our own values, motives, fears, and passions. We reflect. We pour over the lives of patients we may never meet. Though we might make radically different choices than a character, we respect their decisions because we understand the emotional context in which those decisions exist. By disconnecting from the literary threads of humanity, we may *feel* that we fully understand a patient from a ten-minute focused interview when we wholly do not. We risk mistaking bullet points for a complex novel. Thus is the importance of studying humanity as much as we study the human body.

And so, I am inclined to make the distinction between those who treat and those who heal – between those who cool the fever and those who warm the soul. Although biased, I am optimistic that I have the soul of a healer. I fear, however, that current systems (and a lack of good literature) have molded my body into one that only treats. I like to think that my soul, knowing its own cachexia and seeking sustenance, guided me unconsciously towards this reckoning with reading. I feel I have been warned and made aware of the dangers of such neglect. For that I am grateful. I have many miles to go before I heal, but I am okay with that because even in the short time since this epiphany, I have come across so many lovely sentiments. I have come to realize that the journey towards healing is filled with woods that are lovely, dark and deep; moons that never beam without bringing dreams; poppets who feel infirm; happy cities whose citizens neither bow down to pestilence nor become saints; and masked figures who arrive at midnight. Beautiful.

I have decided to wade back into the ocean. I still have many water molecules left to count. I am not sure if I will ever finish. Yet counting is now a brand-new occurrence. I need not miserably float, frantically shifting my attention from one infinite square foot to the next. Perhaps I will start with the biggest wave. Or the cool ocean spray that is birthed from a blow hole. Or maybe I will begin with a snorkel and count the molecules that round themselves against scarlet coral. Ah, no! I know what sounds best today. I think I will start on my back, counting the glistening drops of rain as they are liberated from the expansive sky, open like arms.

I still do not know how to read. I am learning.

# NAVIGATING A THREE WAY CONVERSATION

Christina Gu

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My parents constantly worried about my health when I was a child. They ensured that I attended annual checkups, received all my vaccines, and if anything seemed out of the ordinary, they were quick to bring me to our pediatrician as a walk-in patient by the end of the day. My mom was especially vigilant. I remember getting ready one morning for daycare and complaining about a crick in my neck after sleeping on a new pillow. To the clinic we went. None of this was because I was particularly sickly—I had chickenpox, strep throat, and other milestone illnesses that my playmates also caught—but rather because I was their first child and they were protective new parents. They were also first-generation immigrants with few friends and limited familial guidance to help navigate the American healthcare system.

The year I developed signs of a severe food allergy, my parents and I were seen by a handful of specialists. The providers we saw were unfailingly patient and kind. During our last consult, however, the physician breezed through the history-taking, walked us out of the room and told us: “if possible, I suggest you bring a friend next time who can speak better English.” My parents returned the remark with awkward chuckles. But on the drive home, they discussed names of family friends and coworkers who could help translate for future visits. If it meant I could receive what they believed to be the best treatment, their pride was but a drop in the bucket.

I often think back to this encounter. At the time it did not strike me as odd to ask for help translating. Occasionally, I would edit my dad’s emails and correct my mom’s pronunciation. Over the years, however, that perception has changed. I’ve realized that more could have been done to create a better experience for both my family and the allergist. I have since worked in various health systems and settings over the course of my undergraduate and medical education. One thing remains constant, the option of inviting a medical interpreter into the room.

In 2019, more than 25 million people living in the US self-reported that they spoke English less than “very well” and were considered to have limited English proficiency (LEP). Studies show that LEP patients have worse health outcomes compared to their English proficient counterparts, likely due to a poor understanding of their condition and care.<sup>1</sup> By addressing health literacy, increasing patient satisfaction, improving patient adherence, and reducing adverse events, a medical interpreter creates the foundation from which a patient-physician relationship can be built.<sup>2</sup>

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Delivering the message, however, is not easy. Each word exchanged between patient and physician is sensitive to cultural, environmental, and emotional interpretation. And what if another family member in the room begins interjecting during the conversation, wanting to be helpful? Or if a nurse entering the room supplies additional information about the patient? The medical interpreter must navigate these elements, sometimes picking and choosing from multiple voices to convey what they deem most pertinent to the receiver. Effective communication thus requires an enormous amount of trust in all parties to be successful.

Medical interpreters come with their own set of headaches. As a medical scribe working in an emergency department, I often overheard providers complain when a non-English speaker was added to their list. “It’s the interpreting system,” one attending told me, almost sheepish. “It just takes so much time”.

I could only agree. It was frustrating to watch. First, the patient would be roomed. Then an order would be put in for an interpreter to arrive. During the day, this would usually be an in person experience. During peak hours or overnights, a video monitor on wheels would be sent instead. Both options could take over an hour to become available. The video monitor needed to be plugged in, set up, squeezed into a room already cluttered with wires, equipment and human bodies. If the wi-fi connection was poor, this took even longer.

But it was not just logistical issues. Conversations became long and exasperating for both parties as physicians asked the same question in multiple different ways, sometimes due to undetected issues with health literacy. Other times, they lacked trust in the interpreter. It was not uncommon for me and the physician to exchange doubtful looks after an interpreter transformed a robust explanation of a treatment plan into their own spark-notes version of a few phrases. Even worse, patients could also mistakenly perceive the provider’s rising annoyance and exhaustion as a personal attack.

I recently asked my mom about the experience with the allergist in my childhood. We hadn’t followed up with him, choosing another specialist instead. “It’s not because he couldn’t understand my accent. He just didn’t seem like he cared about us,” she said.

The patient’s ability to read the room does not require a proficiency in English. We all understand this well. I remember the times as a medical student when I locked eyes with a mother while the child in her lap giggled at the touch of my stethoscope on her belly. Another time, when my attending grimly studied scans of a metastatic cancer in silence while the patient’s wife shook her head. Those emotions easily penetrated our language barrier. As we look to the future, improvements in technology as well as interpreter and physician training will make visits more productive, user-friendly, and hopefully, more meaningful. However, more than ever do we need to remind ourselves to cherish the time spent with patients and to treat each other with compassion. This is how we can provide a truly patient-centered conversation.

# THE BORBORYGUS DYSPEPSIA OF MEDICAL JARGON

Kristine Nachbor

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Proudly smiling at my mother, I announced, “Your cranial nerves are intact.” Instead of returning the smile, she looked surprised and confused. She understood the words but questioned the meaning behind nerves being “intact.” And, truthfully, I did not fully understand it well enough to explain it to her. As a first-year medical student, I had unknowingly immersed myself in the imprecise world of medical jargon.

Since my first year of medical school, I added many more words to my elitist repertoire. These words include flatulence, rhinorrhea, dyspepsia, borborygmus and horripilation. When asked, medical professionals report that these words aid in more effective communication. For example, the single word of borborygmus is meant to describe the intestinal gurgling in a more precise way. As a first-year student I often wondered if this “seeming precision” came with a loss of something else; did we lose effective communication with our patients by being more precise with our medical terminology? At times, I wondered if these words truly helped medical personnel communicate better, especially since we still have words that have eluded a uniform pronunciation, such as duodenum.

However, what was more surprising than talking about farting and boogers on the daily, was learning a new secret language. As a child, I had always wanted to create my own secret language. My goal then was to evade others by using my fabricated language to circumvent understanding. As a medical professional, my goal has changed. Instead of trying to evade understanding, I am trying to connect with patients. I am trying to help them understand complex biological, social, and psychological processes to aid with their decision making. To accomplish this task, I have become proficient in a language that the majority of America does not understand. Evidence suggests that 36% of Americans have basic or below basic health literacy skills [1].

Low health literacy is detrimental in a myriad of ways from not understanding diagnoses or medical procedures to confusion around medical finances (with medical being the leading cause of bankruptcies in the U.S [2]). This especially plays-out when healthcare professionals are discussing sensitive topics that may need timely decision and plans, such as in the field of oncology. Research has shown that common words used in oncology—malignant [3], metastasis [4] and remission [5]—were not understood by patients. At the basic level, the medical community needs this understanding. We should know that terms we use as medical professionals are not found anywhere else in people’s daily lives and, so, are understandably not understood.

Yet, it seems that we already know this fact. A recent study found that many fourth-year medical students are pessimistic about patients’ understanding compared to first-year students (55.5% vs 58%,  $p=0.004$ ). But, this same study, also showed that this recognition does not change the use of medical terminology or improve the understanding of patients [6]. This then leads to the question of how to foster environments of mutual

understanding if increasing awareness about the harms of medical jargon does not lead to improved patient-provider communication.

I believe increased understanding comes from strengthening our own knowledge and applying it through practice. Medical school teaches students to improve their physical exam skills through practice. Similarly, we should work to strengthen communication skills with every patient encounter. We can start by reintroducing words such as boogers and farting into our medical curriculum. We can practice moving from medical terminology to patient-centered language. And before we know it, the borborygmus dyspepsia of medical jargon will be just that, bad episodes of gastritis that we reminiscently joke about.

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# THE POWER OF WORDS

Marissa Wheeler

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It was a typical December evening when I drove home after a ten-hour day on my dermatology elective. The walk to my car was chilly, the roads were sloppy, and the traffic was of course sluggish. The day had consisted of continuous 15-minute appointment slots and multiple patient visits for atopic dermatitis, acne, and hair loss. I had been enjoying this dermatology elective, and a few times a week got the opportunity to meet a patient with a rare skin disorder, but overall, I had been spending any free moment counting down the days until winter break and making plans for what I was going to do with my newfound freedom.

Today, something felt different from my usual routine, but I couldn't figure out why. I enjoyed looking at the glittering lights of the city and was grateful for the long walk back to my car because I was getting some desired exercise in. There were many things I needed to accomplish that evening, but for the first time in a long while, I wasn't worried about it. I was actually smiling as I answered emails and cooked a delicious dinner for myself.

My roommate, also a medical student, came home a few hours later and per our typical routine, we asked about each other's days. Usually this consisted of complaining about residents, attendings, mean patients, or just medical school in general. I let her tell me about the derogatory comments her resident had made during lunch, and then when it was my turn to talk, I just said, "My day was surprisingly really good." She was a little stunned by this answer and asked what had happened that made it a great day. I thought about it for a moment because I really wasn't sure myself. I quickly scanned my brain of the day's events, but nothing amazing stuck out to me. There were no "zebra" patients, I didn't get free lunch, and some of my patients had even been fairly challenging. I came to the conclusion that I had been in a good mood all day because of something that had happened early in the morning right when I arrived to clinic.

The previous day I had worked with a new attending. Her clinic schedule was very busy, just as they always are, and we had many complicated patients back to back. I did my best at history taking, presenting, forming plans, and writing thorough notes, and left at the end of the day worn out and ready for some much-needed rest. This morning when I sat down at my work station, my attending arose from her chair and walked down the long hallway to me. I was instantly worried I had done something wrong. Instead, she told me that she had read all of my notes from the previous day and wanted to thank me for the great job I did on them. She had noticed I had put in a lot of time and effort into them. She had a bubbly and loud personality, so a few other students and nurses had heard what she said. My first instinct was to be embarrassed, and I just stammered "thank you" as fast as I could.

Now, relaying this story to my roommate, I was proud of this compliment and told her how amazing it was to hear that my work was appreciated and that I felt like I was truly wanted as a part of her care team. This simple and quick exchange of words had stuck in my head the entire day and brightened my mood. Our conversation then turned to

how rare it is that we receive compliments and feedback on our strengths from our superiors, besides when they are forced to do it as a part of our mid-rotation evaluations which feels very disingenuous. On a typical day, all we hear is constructive criticism or a back-handed comment such as “you are alright for a medical student”. We agreed that the best part about this episode was that she had taken time out of her day to find me and thank me, even though there was nothing requiring her to do so.

Over the next four weeks of the rotation, I only worked with this particular attending five more times. However, each day I worked with her I found myself waking up happy and eager to go into clinic. I wanted to do my best and found that I liked learning more those days than others. Each day I worked with her, the attending would compliment something I was doing well either immediately after I did it or at the end of the day. It varied from thanking me for talking to a complicated patient to telling me my presentations were improving. Each time, I felt giddy and couldn’t stop smiling. I have received many compliments throughout life, but I think medical school unfortunately has a way of making you feel like you are never doing enough: that perfection is just expected. I didn’t realize how much I was craving someone to thank me for working hard. I don’t want to give the impression that she exclusively gave me compliments because there were definitely times we discussed things I could improve upon, but even these conversations left me with a positive attitude.

Over my winter break, I couldn’t stop thinking about how this attending had turned an okay experience into a great one. I mustered the courage to email her and thanked her for making me feel like a real team member and encouraging my learning in an optimistic manner. This experience was not dramatic or life changing, but I think most medical students would agree that in the depths of studying, overnight shifts, and USMLE exams, a compliment from someone you look up to goes a very long way.

# "I TOOK THE PILLS": COPING WITH EXPECTATIONS IN MEDICINE

Lucas Zellmer

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My child psychiatry rotation began with the understanding that my career would not include children or psychiatry. The limited availability of advanced courses that would fulfill graduation requirements led to an interesting decision: opt for an advanced surgery rotation or an advanced psychiatry experience. As a budding internist, I of course chose the option that would ensure a safe distance away from any surgical suite. Now three weeks into my rotation, I am getting increasingly comfortable talking to teenagers with a range of psychiatric diagnoses, levels of participation, and understanding of their illness. Although this semblance of comfort took weeks to build, it took a single challenging conversation to retreat.

Our morning virtual rounds led us to “Sara”: a high school student with crippling anxiety, depression, and PTSD who struggled in school due to specific learning impairments. She presented to the Partial Hospitalization Program after two separate suicide attempts and was transitioning well to the group therapy setting. After Sara entered the virtual breakout room, it was clear to me – and, as I would learn, blatantly obvious to my attending – that something was not quite right. My usual series of questions, including some more pointed ones, yielded more avoidance than objective information. My attending finally stepped in and skillfully uncovered that Sara attempted suicide several hours earlier. The events following this revelation happened quickly; Sara’s mother was asked to enter the meeting, she was updated, and it was agreed that Sara would be taken to a nearby hospital.

At this point in my medical education, I have shared conversations with actively psychotic individuals, families who just lost a loved one, and patients receiving terminal diagnoses. Despite these experiences, Sara’s story seemed to hit me differently. My initial thoughts centered around the reality of mental illness and what it means for a patient to die by suicide. What had happened, or not happened, to Sara to make her feel death was the only cure for her suffering? What does she need from me? What can I actually do for her? These early thoughts reinforced a certain humility in me; the very practice of humanistic medicine underlies the importance of recognizing what I can and cannot control in a patient’s life. As I waded through possible answers to such questions, I felt many of the same emotions Sara described to us. I was scared for Sara, I was sad that Sara had to live with such an illness, and I was anxious as to what Sara’s treatment trajectory would look like.

As I continue to reflect on Sara’s story, I now question the pursuit of normalcy in medicine. Much of what I have been taught both in the classroom and on the wards is how to get patients to “normal”; we monitor labs to make sure they are within “normal” limits and we perform scans to ensure “normal” anatomy. In Sara’s case, I do not know what normal would or should look like. Sara’s psychiatric diagnoses, although persistent and severe, are seemingly one aspect of hardship in their life. Sara has experienced significant physical trauma, homelessness, and

numerous other social needs in less than two decades of life. As a future medical provider I have hope for Sara's future, however, this optimism is balanced with very real expectations. How could I expect someone to overcome such psychiatric illness when mental healthcare remains stigmatized in medicine? How could I expect any medical intervention to work in the setting of overwhelming social challenges? What does a safe, normal life look like for Sara? At this point in her treatment, the hope I have for Sara is static; I hope she does well in the hospital, transitions to an outpatient treatment program, and consistently receives appropriate social and mental health support. My short time with Sara epitomized the role hope played, even in the face of realistic expectations, in the care of struggling patients.

# A LONG SCROLL AND A CURLED MOUSTACHE

Monica Ngo

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“I’ve never seen you before, you’re early, and you have a short white coat on. You must be a medical student?” inquired the lead doctor as she smiled and introduced herself. I was secretly excited and impressed that my role had been recognized so quickly. “We’ll meet as an interdisciplinary team before Huntington’s clinic officially starts.” At the meeting, there were a multitude of specialties represented including a speech pathologist, dietician, social worker, physical therapist, and occupational therapist. “Wow, it’ll be cool to witness how each specialist works as an integral part of this care team,” I thought to myself.

Huntington’s disease is one of those classic genetic conditions you learn about in medical school – the infamous CAG trinucleotide repeat. The disease presents earlier and earlier in age with subsequent generations. I had never seen a patient with Huntington’s prior and was excited to meet my first patient. I took a deep breath and opened the door to my patient’s room.

“Has anything changed since your last visit?” I asked the patient who was about my age. As I went through my list of questions, it was impossible to ignore the uncontrollable, ataxic movements evident in my patient’s arms and feet. “Touch your finger to your nose. Now touch my finger. Nose. Finger...Good!” I chimed. I went through a few more physical examination exercises, then returned with an attending – one of the lead doctor’s colleagues.

“It is so very good to see you all,” said the attending as he addressed the patient and her guardians in the room. He proceeded to sit down on a stool, ensuring he was directly facing her and that the gap between him and the patient was small. His white moustache curled up, and the number of wrinkles on his face increased as he smiled. “Now, we’re going to play a few games” the doctor stated in a soothing cadence. “First, I want you to close your eyes,” he instructed as he gently held her hands. While he observed her movements intently, I noticed a sense of calm befall the patient for the first time, overcoming her previous restlessness. “Next, I want you to touch your finger to your nose. Now touch my finger. Nose. Finger. Nose...,” the doctor continued as he finished the rest of the patient’s visit. The interaction between physician and patient that I had witnessed was undoubtedly tender and ethereal, clearly contrasting the bland but similar checklist of questions I had just asked the same patient minutes prior.

“I want to be a doctor like that one day,” I thought to myself with both admiration and frustration at the unavoidable growing pains of perfecting the art of medicine.

After I had finished working with that particular attending, the lead doctor pulled me aside and said, “Hey, let me show you something.” She unrolled a long scroll which seemed to stretch 3/4 of the length of the team center – easily over 10 feet. Its edges were frayed and color dulled. On it were numerous pedigrees illustrating generations

worth of families impacted by Huntington's disease in the state of Minnesota. "This is what really gets my blood going. I've taken care of the parents of many of the patients you saw in clinic today. We try to provide the best counseling we can regarding family planning. And because this community is so close, I could probably pick out a person in Minnesota who has been affected by Huntington's disease off the street just by inquiring about their last name and looking at the color of their hair. I'm hoping that by the end of my career, my research will have contributed towards a cure for this terrible disease."

"Wow, it's truly incredible how deeply she cares for and knows her patients," I thought to myself.

When the last patient was seen, another interdisciplinary meeting was held to debrief the cases of the day. "There is one patient I want to discuss," said the lead doctor. "I talked with one patient, severely affected by Huntington's disease, who has decided to voluntarily stop eating and drinking (VSED). She was accompanied by her partner and does not appear to be depressed or actively suicidal. In fact, they had recently toured multiple national parks across the country, acknowledging this would be their last vacation together – a final parting gift. The doctor paused with tears in her eyes but quickly regained composure saying, "This was something they had both clearly discussed and had been planning for a long time. As physician-assisted suicide is not legal in Minnesota, I told the couple that VSED is a very reasonable choice in deciding not to prolong death. Does anyone have any ethical concerns or disagreements about my decision?"

No one objected, but one of the nurses added, "It's the compassionate thing to do."

"You know, there seems to be a common theme between the few Huntington's patients I've seen who have chosen VSED. They always appear to have an indescribable sense of acceptance and assurance. It's an aura unlike the sadness or distress evident in those suffering from depression or active suicidal ideation," responded the doctor.

"They experience peace. This is a way they can take control of their own life," the physical therapist answered.

I left the clinic that day feeling confused and conflicted. On one hand, I had been so incredibly touched by the trust and connection that could be made by a physician and his/her patient in the face of a chronic, terminal disease. On the other hand, the limits of medicine were so blatantly real. It was magical witnessing interdisciplinary care in action; and yet, I can't imagine the flip-side where every long visit is a subtle reminder to patients (and their families) that they are really sick. The only conclusion I could muster was not to minimize the importance of various subtleties in the art of medicine: physical touch, cadence of speech, and the respect for patient autonomy. In a scenario where life versus death is not an option, subtleties may truly make all the difference.

# BIPAP

Michael Burgdorf

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*“The way we deal with loss shapes our capacity to be present to life more than anything else. The way we protect ourselves from loss may be the way in which we distance ourselves from life.”*

–Rachel Naomi Remen, MD

DATE OF SERVICE: 10/12/2019

SUBJECTIVE: Patient reports that she hates her BiPAP; patient also reports that she has no friends or family that she stays in touch with or that care about her; her body revolts against her and sends pain signals to her brain whenever she requests movement; she is waiting for the medical system to turn her life around and fix her chronic conditions, and until then she will spend her time watching youtube; she would like all life saving measures in the case of a code. OBJECTIVE: Patient has been wheelchair bound for years—needing assistance even to bathe and go to the bathroom; she has only just started adulthood and needs money from disability insurance to live; she is on ever-increasing amounts of opiates and gabapentin just to make it through each day; her heart is breaking down from years of CHF and her brain is chronically, dangerously inundated with CO2 from her chronic COPD and lack of respiratory ability; she becomes upset at most nurses that step in her door for answering questions that she did ask and failing to give her information that she did not ask for; did I mention she hates her BiPAP machine (?)—like really hates it. ASSESSMENT: Medical school did not prepare me for this. PLAN: Consult a source with more empathy than the UpToDate article on COPD... appreciate recs; continue BiPAP.

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When I met this patient, just months into the wards, doctors told me she was a “fighter.” Despite so many setbacks and so much suffering, she and they still valiantly fought to make it through—trying every treatment and sparing no expense. She did not know her prognosis; she did not know what doctors thought about her chances of recovery. These topics were too emotional, and doctors had already heard what they needed to hear: “full code.”

DATE OF SERVICE: 10/19/2019

SUBJECTIVE: Patient reports she still hates her BiPAP; she is doing well this morning... wait, now she adamantly reports she hates being here and is frustrated with all of her medical staff and lack of answers... wait, now she is doing well again; I think the patient is conveying she still wants all interventions in case of a code; “Am I... dying?” she questions, suddenly on the verge of an emotional breakdown; we panic and fall back on our medically-complex uncertainty—hoping only to stabilize the situation; “No?! Then why did you scare me like that?!” OBJECTIVE:

Patient grows slightly more somnolent day by day as CO<sub>2</sub> continues to rise; it is either BiPAP or intubation at this point and consulting docs have already recommended the latter; patient has not been too keen on the BiPAP thus far; of course the patient is dying, but we did not adequately convey that—clearly no doctor has broached the subject. ASSESSMENT: Are we even providing care? Or are we pouring resources and false hope into this patient, trying to avoid the honest conversation? PLAN: Continue BiPAP.

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I would not spend time in palliative medicine for over a year, and I would not hear doctors use the words “worry,” “wish,” and “wonder” until then. I worry that we all did our patient on BiPAP a disservice by labelling her as a “fighter” in a situation that has no winner, loser, or grit—only degrees of awareness, acceptance, and support. I wish her story could have been different—that someone with compassion and patience could have really heard her and cultivated a conversation about goals of care as well as realistic prognosis. I wonder how her treatment plan and her quality of life might have changed if she had known choosing to lessen suffering is not “losing” and that befriending mortality is not the same as giving up on life. No, unfortunately, we did not do any of this whether by ignorance, inconvenience, or fear. Instead, we continued BiPAP.

# DEATH AND GARDEN VEGETABLES

Elle Maureen Newcome

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There is an app on my phone that reminds me I will die 5 times per day. Did you know? There is an app for that.

A tattooed chaplain I had dated introduced me to the app, and I had paid 99 cents for it. Apparently, those that contemplate their mortality live longer and happier lives than those that do not.<sup>1</sup> This is a practice in Bhutan.

This is not a practice in America, land of the free mammogram and home of the medically adept. In America, we marginalize death, so as not to spook the living.<sup>2</sup>

Once there was a patient who received a palliative care letter. I did not know her at the time. Accidentally on-purpose, the letter was sent. She was not ready for the letter, I heard, yet the letter was ready for her.

Whispers were that it was patented as a 'patient relation' issue, and the Sender was never found. (Perhaps it was a modern medicine issue, where palliation means death, and death is failure.) How hopeful it is to deem an appropriately-timed letter offensive.

Someday, I want to be buried by humans with this hope. I imagine them curious, folding me back into the earth, unsure of what may become of my carcass. I imagine specks of ground freckling my former face like sunshine. The shovelers would powder-dust me with dirt like a bundt cake. Maybe they'd expect a poppyseed of me to germinate. Perhaps I'd reincarnate as a worm or dirt.

The next day in clinic, we met.

She sat, posture perfect in a lime green gingham button up, legs crossed neatly and acid-wash jeans pressed precisely. Little silver rings circled her fingers and a delicate chain looped her neck, dipping into her sallowed clavicle. I thought she looked thin, fit. Our attending said she was wasting. I wonder if I will be that willow during my decomposure, or if I will bloat up, thick with steroids.

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1. DeWall, C., & Baumeister, R. (2007). From Terror to Joy: Automatic Tuning to Positive Affective Information Following Mortality Salience. *Association for Psychological Science*, 18(11)
  2. Institute of Medicine (US) Committee on Care at the End of Life; Field MJ, Cassel CK, editors. *Approaching Death: Improving Care at the End of Life*. Washington (DC): National Academies Press (US); 1997. 2, A Profile of Death and Dying in America

She ate brassicaceous vegetables. Minded her manners. Exercised, probably. Portioned meals, I presume. And still had pancreatic cancer with a 2 year projection at best. You can do everything right, and you will still die.

This is when I downloaded the chaplain's app. I see myself in her, and I want to be ready when I receive my palliative care letter. I want to be ready right now. Not everyone is gifted an expiration date.

Humans are farmer's market veggies: fresh, plucked, vibrant, and earthy to the core. Some sit, ready for acute devouring under the hot summer sunflower sun. Some wait, chronically nestled into artificial cooling devices for later sizzling with cooking devices and saucy spices. Unlike an egg carton, there is no neat, electronic print of a 'best by' date for fresh produce. Like humans, you know when vegetables are past their prime by appearance, varying by make and model and care.

One week later, an electronic notice bolded a tomato-red emergency department visit in the chart of my green-ingham patient: symptomatic gallstones.

So begins the *deterioration*, I think. I regret thinking this way. I like her.

*So begins my jading* of which people speak. Empathy declines, they say.<sup>3</sup> Somewhere between idealistic medical school beginnings and humbling clinical rotations, students begin comparing patients to farmer's market produce, an 'ob-vegetification' process. Snap-judgments rank patients on a sliding scale of ripeness. Disease progression ranges from small perky spinach, to thick-leaved spinach, to 'probably-ok-to-eat' spinach, to dark wilted-spinach, and finalizes with spinach that coalesces into a green-kelp goop at the bottom of a plastic bag. *chilling*.

I want her to be thick-leaved spinach. I want the silver rings on her spindled digits to fit properly, like rings on thick asparagus fingers. Her fingers are slender haricot verts. The tasteful rings slide wildly, clanging together with movement.

With a knife they went into her bloated belly, after the red and furious gall. On the monitor I did not see the cancer. I wonder where it lived in her. I could have looked it up, but I did not, out of misdirected reverence. They stapled, cut, and caught the swollen gallbladder in a plastic fishnet baggie. Then, they pulled it out of her, spattering red beet juice on the blue, billowy drapes. Then, they desufflated her abdomen.

I guess they left the cancer inside.

After surgery, the rice crispies under her skin crinkled like tissue paper when I touched her. That is when I felt the fragility of separated sinews. Delicate, like frosted lace.

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3. Chen, D. C. R., Kirshenbaum, D. S., Yan, J., Kirshenbaum, E., & Aseltine, R. H. (2012). Characterizing Changes in Student Empathy Throughout Medical School. *Medical Teacher*, 34(4), 305–311

I am of this gossamer material as well. At this moment, she has her place in medicine, as I have mine. We both have plots in the planted ground and a finite quantity of ripened seconds above it.

She will die. The chaplain will die, as will I, outlived by a 0.99 cent app that predicts our shared certainty.

# THE GLASSBLOWER

Sarah Reyna

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I sat at my computer screen as a fourth-year medical student, thinking about the residency interview season ahead. I had just watched some informative videos about the type of questions interviewers might ask me, and how I could respond in a way that was both authentic and complimentary, eloquent without sounding rehearsed. My top-choice residency programs were outside of the Midwest, and I felt that I really needed to pack a punch and make a good impression. However, I'm also an introvert and didn't want to come across as disingenuous.

So I sat at an empty Word document, and thought about how I would respond to my interviewers' inquiries, but my brain seemed stuck – as blank and uncommunicative as the white screen in front of me.

Since those canned questions weren't sparking any inspiration, I made up some new ones for myself: "Who are you? What are you? *Why* are you? Who do you want to be? How will you become it?"

As words finally began to spill across the page, some of the answers I came up with were the same as they would have been 4 years ago, when I applied for medical school. "I want to be a kind and humble physician." "I want to do no harm, and not prescribe medicines or procedures that aren't improving people's lives." Some were new, and would have surprised me back then. What kind? "A med-peds physician. A primary care, outpatient physician." (I didn't even know what those words meant when this all started.)" Some were due to an increased awakening of conscience. "It is my job to disassemble systemic racism in the health care system. It is my duty to figure out ways to incorporate restorative justice into my practice of medicine."

Some were not related to medicine at all. "I am a mother. I want to be there for my children. I don't want to miss a single smile or a single milestone. I am a wife. I want my husband to know he is my rock, and that my calling as a doctor is second in my heart to my calling within my family, even if it cannot always be second in how I spend my time." You see, I had now experienced what some doctors go through, and what they sacrifice for their patients. I had listened to a nurse in the OR as she told me that the worst part of her job was watching the families of physicians fall apart — that her least favorite moments were when a surgeon asked her to call their spouse to let them know they weren't going to make it home for their young daughter's soccer game, or anniversary dinner, because a patient could die if they were to leave. Now I know that one of the most important parts of my future job is finding balance, and passing the baton to the next provider so that I can continue to take care of myself, my family, and our life outside of medicine. I have learned the hard way that if I don't take care of myself and my family, I can't take good care of my patients either.

As a kid and teenager, I was praised for being so high-achieving—for being a good student, an athlete, a coach, a member of the band and choir, a cantor in church, and a volunteer in my community. My mother was so immensely proud of me, but she was the only one to see what it did to me—the lack of sleep, the pressure. She

always told me to slow down, that I had to say no sometimes, but I hardly paid her mind. During university, I heard self-care buzzwords of “Treat yo’ self!” and “You deserve it!” that were just annoying to me when I was battling to get nutrition into my body, sleep a couple hours a night, and pass calculus, organic chemistry, and genetics at the same time. During my second year of medical school, I had a lecture about The Quadruple Aim, explaining the idea that care of the patient requires care of the healthcare provider. I appreciated everything they discussed, but also scoffed internally at the thought of being allowed to be human, in the midst of the long hours I was required to put in, in order to succeed. On Facebook support groups for moms and stepmoms, I felt the seeping sharp edge of jealousy creep into my soul as I saw the hours some mothers poured into educational arts and crafts for their children, when I couldn’t even make it home to read a story at bedtime. This year, I had especially heard strong refrains about self-knowledge and self-betterment in the context of an anti-racist society. The thing is, I WANTED to slow down and concentrate on being a better human. However, through all I remember of my life, my internal compass and institutional feedback have been pointing, pointing, pointing to the next, the bigger accomplishments, the longer journey, with no destination in sight.

*Why am I?* That one I had to think about for a long time. I took a hot shower to help soften the thoughts, to feel them melt into swirling emotions and abstract notions, and harden into comprehensible words. When I had dried off, gotten dressed, and wrapped my hair in a towel, I wrote down, “The best version of me makes the best version of *we*.” It was such a simple statement, seemingly cliché, but intensely meaningful to me in that moment. With everything that was going on in my household, in my rotations, in my city, country, and world, this statement was something for me to contemplate and strive for. We need to be better, which means I need to be better. And if I’m going to be better, I need to treat myself as a complex human being with a complex hierarchy of needs. Abraham Maslow is famous for his pyramid of human needs that ranges from sleep to security to self-actualization, but I’ve found that what can happen under stress is a breakdown of that pyramid structure. I know, because I’ve broken it. I’ve skipped meals and sleep. I’ve held back from peeing for hours because I didn’t want to deal with the shame and repercussions of scrubbing out in the middle of a surgery. I’ve sidestepped morality to save face in front of an unreasonably strict attending. And I know I’m not the only one. I know that because of whispers in a quiet hallway of “what just happened in there?” I know that because of sympathetic glances shared between equally dark-circled eyes after a shift that was too long to be safe. I know that because there were amazing people in our classes that are no longer here despite reaching what appeared from the outside to be coveted self-actualization.

My time in medical school has been so incredibly difficult. What is so critically important for me is to focus on the good that can be found within the struggle. I used to look for the light at the end of the tunnel, but that got old quickly when the tunnel turned out to be 11 years long. Now, I try to focus on the beautiful things and moments that are in the tunnel with me. Life, even a life filled to the brim with privilege, can be really hard. It can also be full of compassionate conversations in a resident workroom with old and new friends, of rainbows after a storm, of golden minutes of sunshine, of fresh icy walks in a frozen forest, of sweet baby breath exhaling from sleepy rounded cheeks, and of tender toddler cuddles on stolen time. But somehow in the heat of the moment, on a night shift where the gears of my brain refuse to move and my differential diagnosis is 3 diagnoses short of 3 diagnoses, that “*why am I*” is extremely difficult to recall. Self-care is so far down on my priority list, below “Finish H&P. Call

consultants. Make birthday cake. Sleep-train the baby. Call the dentist. Clip your nails. Fill out the 6 MedHub evaluations that you've been getting emails about for the last month. Teach fractions to Raquel. Pay the rent."

The final question I had written was the one that, for me, was the most hopeful and also the most haunting. "How will you become it?" With the scarcity of time and energy that is my wonderful, chaotic, impossible and yet somehow possible life, how do I find time and space to change for the better, and to become the mother, wife, daughter, sister, physician, coworker, leader, and human that I want to be?

There are so many ways I could answer this question, but an image pops into my mind as I'm so diligently avoiding the prescribed interview questions in order to mull over these much more crucial ones. It's an image of a glassblower in the Canal Park area of Duluth, MN, blowing a beautiful blue vase into existence from what had recently been just a pile of coarse sand. I feel the cold lake breeze moving across my face and watch as it hardens the scorching-hot liquid into an elegant form it may never have expected to become. Coming back into this current moment, I set down my cup of tea, take some deep breaths, and put my faith and trust in the Glassblower. "I will do my best," I tell Him. "I will try to move when I need to move, and be still when I need to be still. My coarse best is all I can be. Please help me to come out beautiful."

# CROSS COVER EMERGENCIES

Megan Crowe

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I was finishing up my second week of my fourth year medical ICU rotation when I got my first cross-cover call. The prior two weeks had prepared me to expect life and death emergencies; just a few hours prior a Ludwig's Angina patient had pulled out her own breathing tube. It was nearing the end of the night and amid the regular beeps and clamor of the ICU unit, I heard a ruckus at the end of the hall. I learned quickly that the ICU is not a quiet place, and people shouting was not completely out of the ordinary.

"Can you take this one?" the intern mouths to me and hands me his pager as he's on the phone with a consult. All the pager says is "Room 612." Signout hours earlier had been a blur. I scanned the handoff sheet and found 612: "92-year-old woman here for altered mental status" – which could be anything. Feeling quite like a child soldier gearing up for battle, I slung my stethoscope around my neck and headed down the hall. The yelling got louder until I came to stop in front of room 612, the source of the commotion. Outside the door I was met by the nurse who appeared to have at least fifteen extra years of experience on me. Exasperated, she gave me a momentary smirk as if to say, "great, they sent the student". I couldn't blame her. She quickly regained her composure and informed me "Ethel is sundowning hard. She spits out all of her pills, including her home sleep aid, Zyprexa. Can we give her IM Haldol?" I was acutely aware of the absurdity of the situation: the nurse, who had seen about a thousand such patients was asking me, who had been in the ICU for all of two weeks, for advice.

"Help! I want to go home!" I heard from the room, confirming the nurse's assessment. Why do they always have to yell "help"? It feels like we're holding down and torturing a prisoner of war, which in this case didn't seem quite off. In the room, I saw an older woman, presumably Ethel, being held down by a nursing assistant and screaming. "I can see she's quite the handful," was my unhelpful, noncommittal response. I came closer to Ethel and for a moment as she watched me walk in, she quieted, as if she was hoping I was reinforcement to rescue her from her prison. She was thin and had curly white hair; she could be any other elderly woman, but this woman was depending on me to help her. Completely unsure of what to do, I took the momentary pause to speak directly to our patient, "Ethel, we're here to help you. What do you want?" "Water!", Ethel exclaimed. "Ethel," I responded, "We can get you some water. Would you be able to take your pills with the water?" She responded with a terse, "I'm thirsty!" Quickly, the nurse popped the Zyprexa in her mouth and followed it with a sip of water. Ethel swallowed without complaint. One by one, the nurse repeated this with the rest of her medications. When she was finished, Ethel continued to appear restless, but quieter. "Well," the nurse remarked, "If anything else comes up, we know how to get a hold of you." I know that in future cross cover "emergencies" I won't be so lucky as to always encounter an issue that solves itself, but I left Ethel's room feeling a soldier at least slightly more prepared for the oncoming war that is intern year.

# EMOTIONAL TRIAGE

Ryan Duff

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I was midway through a shift in the emergency department during my ultrasound rotation, two weeks away from a much-needed winter break. I waited for my patient suffering from back pain to return from a CT scan so I could perform a bedside echocardiogram. In the interim I refreshed my cardiac anatomy, but my attention strayed to the open electronic health record tab of our most recent patient. COVID-19 positive, worsening shortness of breath, and chest x-ray demonstrating diffuse, bilateral opacities. I scanned their problem list, developing a gestalt of their health and mentally checked off each comorbidity portending poor outcomes for a virus now resurging. My seasoned 3rd year emergency medicine resident prognosticated a succinct yet ominous disposition.

“They’re not going to make it out of this hospital.” I followed her gaze to the room behind me and saw a tortured soul fighting for air as the respiratory therapist increased the oxygen via high flow nasal cannula. I stared blankly for a moment, yet quickly my attention was averted. I caught a glimpse of my patient returning from CT. My resident was busy finishing notes, but our attending physician also noticed their return. He looked at me while pointing to the ultrasound machine.

“Ready?” He barely finished the word before darting toward the patient’s room. I’d quickly realized this was the only pace at which emergency medicine physicians worked. I eagerly rose from my chair and responded. “Let’s do it!”

My attending provided guidance as I felt the prominent rib contours through the ultrasound probe pressed against my patient’s frail frame. A textbook view of the heart appeared on screen, just as my attending was urgently called out of the room. I continued the procedure, awed by my patient’s abnormally large heart, with such poor contractility it bordered on asystole. As I finished up, I thanked my patient for the learning opportunity yet fumbled briefly having forgotten their name. This rare uncouth moment represented a sharp deviation from what is normally my penchant for quickly building authentic rapport with patients. Leaving the room, I recalled past evaluations by residents and staff that corroborated my intrinsic investment into patients’ lives. But immediately after closing the door, a cacophony of different colored scrubs in another patient’s room broke my internal reassurance. An all too familiar scene of organized chaos I recognized as a code.

Two medics, whom I’d worked with before medical school as an EMT, arrived with a patient in cardiac arrest. COVID-19 precautions barred students from assisting in these, so I watched from afar and reminisced with my former co-workers. Moments later, a nurse scurried from a small opening in the sliding door to hand the crew their LUCAS device. We exchanged farewells and as they departed, I heard the echoes of alarm tones emanating from their radios, followed by their dispatcher’s voice. She begrudgingly addressed the crew, provided them a street address, and gave them their next call: “Code 3 – cardiac arrest.”

My focus shifted back to the resuscitation. A fellow classmate and I talked as we gazed helplessly at the ongoing entropy beyond the plexiglass. We discussed potential etiologies of this patient's stopped heart, as well as prudent investigations and treatments. When our view inside the room was obscured, our conversation detoured to life updates, postponed holiday plans, and the fraction of anatomy current first-year medical students had learned compared to our class. "They didn't learn *any* of the pterygoid fossa?!" I exclaimed in disbelief.

"Can we get another amp of bicarb?" Another nurse exclaimed from behind a small opening in the door. I peered through this fleeting aperture to get a closer view of the turbulent exercise of restarting a heart I'd participated in countless times before.

The resuscitation was momentarily successful – a thready, tenuous, slowed heartbeat restored. My attending remained outside the room to console the family over the phone, tenderly informing them of the situation and the grim prognosis. Silence followed, then muted sobs from the other line. They'd made the decision to act in accordance with the patient's newly discovered "Do Not Resuscitate" order. Barred from the hospital given COVID-19 precautions, the family listened over speakerphone while the hospital chaplain gave the patient's last rites. A final ventricular depolarization flashed on the monitor before deafening stillness. There would be no compressions this time.

I was getting hungry as we neared shift change, and anxious to get home. I refreshed my patient's chart from earlier and opened their CT scan images. I challenged myself to read the imaging before the radiologist's report. But the pathology was clear even to my novice eyes. The vertebrae in my patient's spine were peppered with a half dozen or so small, lucent circles representing erosion of bone. As if pierced maliciously by a hole puncher. The etiology of their back pain was clear. I reviewed the rest of their chart.

"Mets," I said quietly, to no one. Metastatic cancer.

"I called medicine and palliative care," my resident exclaimed to our attending as they discussed my patient before sign-out. I admired her astonishing efficiency, having already finished her note from the code. This patient, too, was likely not going to leave the hospital.

My stomach growled.

The oncoming night resident appeared at the workstation to relieve us, and I practiced delivering sign-out on my sole patient. I approached a nurse who'd helped me earlier in the shift with placing IVs to say thank you before heading home. My walk back to the workstation led me past our patient suffering COVID-19 pneumonia. Their battle for oxygen grew more intense as the respiratory therapist traded the nasal cannula for BiPAP.

Another growl from my belly. I found my resident and expressed gratitude for her teaching, solicited feedback, and we parted ways. I hazily remembered the mental map back to my car as midnight passed. I drove straight home – immediately falling asleep and forgetting to eat altogether. I was awoken peacefully by a late-rising December sun hours later. Feeling refreshed with sleep, coffee, and finally a meal, I began a process I'd routinized since starting

clinical rotations that proved crucial to sustaining my humanity in medicine: Writing, reflecting, and learning from the previous shift.

As I began typing, however, the gravity of each encounter began weighing on my conscience. My refreshed energy quickly abated, supplanted by a gnawing grief as I recapitulated the suffering I'd borne witness to. My seeming indifference to this pain, then necessary to focus on my learning and catalyzed by hunger and fatigue, gave way to overwhelming guilt. I recoiled from the keyboard. My eyes closed. My thoughts quieted. I opened up space – to feel. A space to focus on that painful, yet necessary, expression of sorrow unconsciously triaged until now. I surrendered to those emotions, shedding tears concordant with suffering heretofore left unattended. The suffering of three patients and families whose mortality was now palpable. Undeniable. Eventually, my catharsis and tears rescinded, having rehydrated the clearly desiccated but still fertile soil that sprouts the compassion and empathy from which my motivation to practice medicine harbors its roots. I finished my reflections, sobered and revitalized, ready to carry my replenished soul to my next shift.

# A FAREWELL WITH TOMATOES

Marvin So

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“Blame the tomatoes,” you joked.

I chuckled at the thought. Like you, I had tried my hand at growing tomatoes from seed this summer, those notoriously friendly vegetables for novice gardeners. In my mind’s eye, I envisioned crimson and gold orbs bursting through the soil. Graced with morning dew, a sweetness at once vigorous and achingly delicate. Descendants of the sun itself.

You remember them less fondly. As August rays gave way to September leaves, your tomatoes overflowed the trailer park plot. Striped Germans, Ace 55s, and cascades of those curious yellow cherry tomatoes. Such a bounty that you found yourself fixing a BLT every meal for weeks.

Then one morning, the brutal stomach pain. “Must be those damn tomatoes”, you thought. Begrudgingly, you dragged yourself to the hospital, thinking you’d be home in time for dinner. (Maybe skipping tomatoes this time.)

Instead, we talked about white blood cells and bone marrow. Asked you to stay a night, then another. Then a week. We found scarring in your lungs, spurs in your wrists, and plaque in your arteries. You asked us – a faceless room of powder blue cloak and fogged-up plastic – “If they’re not bothering me, can you really call them diseases?”

We took blood. Tapped your hip for some marrow. Told you about something called “poor cytogenetics.” Then the chemo started — a baggie of poison strung up on a mobile coat rack. You called it your new girlfriend, rolling her down the hallway with your uproarious laugh.

I asked you how it all felt in this striking turn of events. With that ragged and gentle smirk, you said, “I feel just fine. Long as I can get out in time to hunt some turkeys.” I gulped and offered a meek nod, knowing that turkey season was starting sooner than chemotherapy was ending.

The next few weeks changed you. The blood in the toilet bowl and sores along your gums signposts that the journey was just beginning. Our morning visits became shorter, less laughter-filled; the autumn sun filtering through the blinds seemed to fall at a different angle now. I noticed the stillness of dust more and more each day.

One morning, the Oncology team sat with you for hours. “The transplant process is really difficult. It will be important to have someone you can stay with. Someone who can drive you to and from the hospital, and take care of your food and personal affairs.”

I remember the quietness of that room, vacuous save for the ticking clock. Piercing the silence, you reminded us, “I told you. I don’t have no one. I can’t ask anyone to do that for me.” These words struck deeply, perhaps more

so because I knew you were a public school bus driver for 20 years. How many families must have benefited from you driving their kids to school every morning for two decades? I imagined all the jokes; the karmic worth of those words.

That quiet day was also my last day on the rotation. It took all of my strength to bring knuckle to door and say goodbye. I dilly-dallied, avoiding the topic altogether during pre-rounding, rounding, and a mid-day check-in. How could I be leaving today, when what you needed most was stability and support?

With exceeding awkwardness, I shared the news that I would be departing. Wished you strength and healing through the steps ahead. As the heavy hospital door latched closed, I felt its weight touch down on my chest. The sight of your face in that moment, slats of hazy sunlight at your feet, I'll never forget.

As medical students, we move through different hospitals for months, weeks, sometimes only days at a time. We see firsthand how the body both becomes and comes undone, and this is how we learn. We accompany our patients through cross-sections of illness, but rarely stay for the entire chapter.

This idea surfaced a challenging tension for me, because it makes obvious that the reason we are there is primarily for our own best interest in *training*, rather than the patient's best interest in healing. Were our discussions about tomatoes and turkeys genuine efforts at building a bridge with another human being? Or was I simply sifting through the sand of your life just to find that clinical pearl? In saying goodbye in the middle of your treatment, it was to say, "I'm leaving now, because I've gotten what I needed out of this experience. I'm good now."

But of course, I'm not good. I can reason why it must be this way. Every student needs to see a variety of clinical environments. Teaching hospitals build the future workforce. Boundaries are necessary in order to sustain ourselves for the long haul. It all made sense, until it didn't at all.

That evening I drove home, exhausted from that long, final shift. It was that exquisite mote of autumn in Minnesota, when the air is sweetly crisp, and the blue sky is flecked with oak leaves and an errant bald eagle, if one looks closely enough. I thought about how much you would have loved it — to walk in the light, rifle in tow, unencumbered by hospital blinds. The vividness of that sky was bluer than any powder blue gown.

It was also the end of the growing season, and time to harvest tomatoes. I visited my plants, and to be honest, I was disappointed in their output. After all, I was hoping for glorious, plump aggregations of crimson and gold. Instead, I saw a few meager, ruddy fruits scattered about. Some flowers never even bore fruit, destined to wither, a dream deferred.

I grasped each tomato in palm, severing it from the stalk and soil they had come to know as home. I rinsed each under the tap, carefully placing them on a towel, and admired the fruit of my labor. They were small and quite lumpy, but they were mine. That unmistakable scent of acid and earth clung, lingering for hours.

I thought about how these tomatoes grew out of sunlight, water, soil — but also from attention and care. I had gently plucked spider mites scurrying up stems, adjusted cages to ensure adequate light, awoke in the night

contemplating soil pH. I visited with them every afternoon, sharing weary stories about the strange and beautiful people I met that day. I noticed these plants, where they changed and grew and decayed, how they became and came undone.

Sometimes I wonder if the tomatoes would have turned out better had I typed my progress notes faster, cut out a visit or two, told a few less jokes.

Of course, this is a false dichotomy. In life and medicine, we are bestowed the mystic, unmerited gift of time. We choose how to use it, but none of us can know the true depths of this well; the vastness of this garden.

As physicians, perhaps there is a lesson we can draw from the master gardener — he who tends to his crop with faith and devotion, season after season. He cannot predict tomorrow's blight, not the infestation next year, yet he shows up all the same. For what is a harvest, if not a celebration of presence?

So too can we offer our attention, care, and *noticing*, despite knowing what lies ahead. For our loved ones, our patients, and yes, even a miraculous, lumpy tomato.

# ABOUT THE EDITORS

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**Anna Wojcicki** is a third year medical student passionate about caring for children, adolescents and women from marginalized communities. In her spare time she enjoys writing, following the NBA/NFL, being in nature and admiring the beauty of new places with her partner.

**Balvinder Singh** is a fourth year medical student pursuing a career in medicine and cardiology. Beyond the wards and the lab, he enjoys getting outside via hiking and biking, ice cream, coffee, and takeout. Balvinder is also excited about his most recent roommate additions, two cats (Sam and Andy), and sharing photos of them, naturally.

**Daniel Ly** is a fourth year medical student continuing his training in Pediatrics at the University of Minnesota. In Daniel's spare time, he enjoys running, biking, cooking, playing tennis, and folding origami. He currently lives in St. Paul, MN with his wife and two rabbits.

**Elizabeth (Lizzy) Kim** is a fourth year medical student who will be moving to Tennessee to start general surgery residency at ETSU. She is grateful for the ability to listen to and to tell stories. She enjoys running, making (but more so eating) ice cream, and spending time with friends and family.

**Julia Weston** is a third year medical student hoping to pursue a career in Internal Medicine or Emergency medicine. She is passionate about social justice. In her spare time, she enjoys cooking, creative writing, crafts, and weightlifting.

**Morgan Turk** is a third year medical student hoping to pursue a career in Psychiatry. She is also passionate about community health and health equity. In her free time, she loves to explore Twin Cities restaurants, do crossword puzzles, and find gems at vintage and secondhand clothing stores.

**Nuwan Pathagamage** is a third year medical student passionate about medical education and improving patient care. In his spare time he likes playing ultimate frisbee as well as watching basketball, football and international soccer. He enjoys eating cuisine from his parent's homeland of Sri Lanka but also enjoys trying different global cuisines as well.

**Octavia Ruelas** is a graduating medical student about to begin her intern year as an EM PGY-1. Her pieces were self-reflections written during her clinical years at the University of Minnesota Medical School. She enjoys scribbling random thoughts on scratch paper, aimlessly wandering through bookstores, and drop towers at amusement parks.

**Ryan Duff** is a fourth year student from the Twin Cities campus. He will be moving to Tacoma, WA this summer to start his residency in internal medicine with an interest in pulmonary/critical care. He enjoys reading, writing, running, learning, and listening, as well as sharing time with friends and family.

**Sarah Reyna** is a zealous human being who cares deeply about seeing and celebrating the humanity of others, especially those who have grown up in less advantaged physical, mental, and emotional environments. She is also a fourth year medical student and soon-to-be pediatrician. In her spare time, she enjoys eating peanut butter out of the jar, traveling, figure skating, and spending time at the lake “up north” with her children, her husband David, and her parents.

**Spencer Ilstrup** is a third year medical student hoping to pursue a career in psychiatry. He is passionate about saltwater reef aquariums, marine biology and literature. In my spare time I like to try new foods, read prolifically, hunt waterfowl and explore wild spaces.

# ABOUT THE AUTHORS

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**Allicen Waxlax** is completing her fourth year of medical school and celebrating her nineteenth year as a registered nurse. She is looking forward to starting family medicine residency to pursue her passions for rural health and diabetes care. When away from her studies Allicen enjoys time spent in her faith community and time camping, hiking, and cooking with her husband and their four children.

**Alycia Chmielewski** is a fourth year medical student who recently matched into pediatrics at the University of Minnesota. She is passionate about rural health and research regarding adverse childhood experiences. Outside of medical school, she enjoys exploring new breweries and tending to her ever-growing collection of indoor plants.

**Baila Elkin** a third year medical student, interested in gastroenterology, infectious disease, and all things microbial. In her almost non-existent spare time, Baila enjoys beading, fantasy fiction, and books about parasites. Although she has written Shakespearean sonnets before, this is her first Petrarchan sonnet.

**Catherine “Cat” Bledsoe** is a fourth year medical student hoping to pursue a career in family medicine and public health. She is interested in the power of stories in the health of individuals and communities. In Cat’s spare time, she enjoys traveling, cooking, baking, and quilting.

**Christina Gu** is a third year medical student hoping to pursue a career in internal medicine. In her spare time, she enjoys cooking, outdoor hikes and runs, or staying in bed with a good book.

**Christy Atkinson** is a fourth year medical student who will be attending the University of Minnesota Medical Center (Smiley’s) Family Medicine Residency Program following graduation this spring. She is passionate about patient advocacy, community-based anti-racist medicine, reproductive health, LGBTQ care, and opioid use disorder treatment. In her spare time she can be found kayaking with her partner, lounging around a bonfire with family and friends, or admiring her very cute cats.

**Connor Dedeker** is a third year medical student hoping to pursue a career in ENT surgery to care for patients with facial trauma, head and neck cancer, and other otolaryngologic issues. In Connor’s spare time, he enjoys learning about the history and art of craft coffee-making, playing golf, and cooking authentic Puerto Rican cuisine. He feels honored to be a soon-to-be physician and looks forward to the many years of patient care that lie ahead of him.

**Curtis Bashore** is a fourth year medical student heading for pediatric residency at Dell Children’s Hospital in Austin, Texas, hoping to pursue a career as a hospitalist, PICU, PEM or NICU attending. He is passionate about medical education and vaccine advocacy. In his spare time, he enjoys spending time with his family, cooking and trying new foods, and hopelessly watching the Vikings miss out on the Super Bowl year after year.

**Danielle Aase** is a fourth year medical student who will be pursuing a career in Ob/Gyn and completing her

residency training at the Mayo Clinic Ob/Gyn residency program. In addition to women's health, she is passionate about medical education and nutrition. In Danielle's spare time, she enjoys cycling and watercoloring.

**Diana Rubio** is a self-proclaimed coffee connoisseur, fitness aficionado, and aspiring family medicine doctor. Throughout her undergraduate and professional career, Diana engaged in community-based research and outreach with the hope of uplifting low-income communities. She revels in knowing that she will contribute to health equity and advocacy efforts throughout her career in medicine.

**Dwayne Gibbs** is a third year medical student hoping to pursue a career in general surgery. He enjoys running, playing tennis with his fiancé, weight-training, trying new beers, and spending time with family and friends. He hopes that sharing his experiences will facilitate more conversations about race and racism in medicine.

**Elle Maureen Newcome** is a former cycling tour leader and current fourth year medical student heading to Phoenix, AZ for internal medicine residency. Elle is passionate about addressing health disparities through medicine. In her free time, she enjoys painting, cross country skiing, and spending time dancing or adventuring with friends and family.

**Eric W. Leppink** is a fourth year medical student going into psychiatry with an interest in community mental health and research. Outside of medicine, Eric has a penchant for surrealist fiction and fantasy, fountain pens, and ultimate frisbee.

**Germán L. Vélez Reyes** is a fourth year medical student in the Medical Scientist Training Program at the University of Minnesota, Medical School. He is passionate about medicine, surgery, and basic science research that uses genetic tools to discover new cancer genes. In Germán's free time he enjoys reading, running, weightlifting, spending time with family and friends, and talking about international politics.

**Hannah Thiry** is a third year medical student hoping to pursue a career in Obstetrics and Gynecology. She is passionate about accompanying patients to their desired and most optimal health, and sees herself as a trusted resource, confidant, and guide along their personal journeys. In Hannah's spare time, she can be found exploring the outdoors, her favorite being the Boundary Waters Canoe Area.

**Himal Purani** is a third year medical student hoping to pursue a career in Medicine/Pediatrics and is passionate about delivering holistic, patient-centered care. She is particularly interested in helping patients and their families navigate unexpected, difficult diagnoses and improving access to preventive care and resources. In her spare time, she enjoys cooking and experimenting with new, healthy recipes, hiking, travelling, and spending time with her family & friends.

**Jacob Krogstad** is a third year medical student hoping to pursue a career in general surgery, and is passionate about access to care and health equity. In Jake's spare time, he enjoys cooking, fitness, and Minnesota sports.

**Jacob Reshetar** is a third year medical student planning to pursue a career in emergency medicine. He is passionate about issues of global health in developing countries, tropical medicine, and humanitarian aid. In Jacob's spare

time, he can be found exercising at the gym, trying out new recipes in the kitchen, or socializing with friends and family at breweries around the Twin Cities.

**Jena Velji-Ibrahim** is a third year medical student hoping to pursue a career in Internal Medicine. In Jena's spare time, she enjoys hiking, baking and spending time with her cat.

**Jessica Flakne** is a fourth year medical student pursuing a career in orthopedic surgery. In her spare time, she enjoys sketching, cooking and gardening.

**John McGrory** is a fourth year medical student pursuing a career in emergency medicine. In John's spare time, he enjoys reading, biking, running, camping, napping, baking, writing poorly, and sewing.

**Jordan Wolf** is part of the UMN Medical School 2022 class. Jordan is passionate about anesthesia and rural health. In her free time, she enjoys fly fishing, backpacking, and exploring her public lands.

**Kevin Butcher** is a fourth year medical student who will be starting psychiatry residency in Madison, WI in the summer of 2021. Kevin was inducted into the Gold Humanism Honor Society and is passionate about the way physicians and health care providers communicate with patients. Outside of medicine, you can find Kevin at the local record shop, laughing with friends, or spending time out in nature.

**Kim Lundeen** is a fourth year medical student pursuing a career in family medicine, recently matched at the UMN St. John's program. In Kim's spare time, she enjoys spending time with her husband and 2-year-old daughter, Josie, and being outdoors as much as possible.

**Kristine Nachbor** is a fourth year medical student who is passionate about creating change in medical education. In Kristine's spare time, she enjoys sculpting and being outside. She believes that each of us has the ability to change the world.

**Lauren Summers** is a third year medical student hoping to pursue a career in orthopedic surgery. In her spare time, she enjoys reading, kayaking, and hiking.

**Lucas Zellmer** is a fourth year medical student who will be completing a residency in internal medicine at Hennepin County Medical Center. Lucas is passionate about equitable access to care and addressing social needs in medicine. In Lucas' spare time, he enjoys mountain biking, wood working, and playing with his dog, Asha.

**Madison Duppenhaller** is finishing her third year of medical school and hoping to pursue a career in primary care with a women's health focus where she can share her passion for advocacy and education with her patients. She and her husband, Trent, are looking forward to welcoming their baby girl in June and are busy preparing for her! In Madison's (limited) spare time she enjoys puzzling, reading fiction, and cuddling her two adorable kitties.

**Madison Ernst** is a third year medical student who is passionate about patient care, cell biology, cats, and cooking. In her spare time, she can be found eating Trader Joe's Dark Chocolate Lover's Chocolate Bars, running, or meal prepping.

**Marissa Wheeler** is a fourth year medical student who is passionate about rural health care. She is pursuing a career in family medicine. In Marissa's spare time, she enjoys spending time outdoors hiking, fishing, and camping with her husband and dog.

**Marvin So** is eager to cultivate health and flourishing by supporting whole family ecologies. He believes the practice of medicine is primarily an act of mending wounds visited upon human bodies by social injustice, working in concert with the many ways we come to heal and build resilience.

**Maya Sayarath** is a fourth year medical student pursuing Internal Medicine at Brigham and Women's in Boston, MA next year. Her clinical interests include women's health, refugee and immigrant health literacy, as well as, community involvement and service. In Maya's spare time, she enjoys playing tennis on clay courts, hiking and biking with friends and family.

**Megan Crowe** (she/her) is a fourth year medical student going into internal medicine. She has a masters in public health and is passionate about social determinants of health and health justice. In her spare time she enjoys running, hiking, and biking.

**Michael Burgdorf** is a fourth year medical student preparing for residency in family practice. Outside of medicine, he loves bike-commuting in the expansive temperatures of MN, watching Rotten Tomatoes approved movies with his wife (Kiki) and puppy (Chester), and viewing the many textures of life through his camera lens.

**Molly Lindstrom** is a fourth year medical student hoping to pursue a residency in Internal Medicine and eventually a fellowship in Hematology/Oncology. In Molly's spare time, she enjoys indulging in Japanese, Korean, and Chinese novels, music, TV dramas, and cooking. She lives with her twin sister, who is pursuing a residency in Pathology, and their two adopted rescue dogs.

**Monica Ngo** is a fourth year medical student who will soon be starting neurology residency at the University of Minnesota. She is passionate about learning all things related to the central nervous system and improving the ways we serve our communities. In Monica's spare time, she enjoys trying new foods, jogging, and watching anime.

**Monica Olivier** is a fourth year medical student who will be beginning her pediatric residency at the University of Minnesota in June of 2021. In her spare time, she enjoys drawing in the hyper-realistic style, cross stitch, knitting, puzzles, cooking and creating recipes, and visiting family in Spain.

**Namrata Damle** is a third year medical student passionate about primary care issues. In Namrata's spare time, she enjoys spending time with friends and family, reading, and doing jigsaw puzzles.

**Nikki Janssen** is a third year medical student interested in OB/GYN. Outside of medical school, she can usually be found in the kitchen cooking and baking or at a craft store browsing for supplies for her next project.

**Paulina Marell** is a fourth year medical student excited to pursue a career in internal medicine. Paulina has had the

wonderful opportunity to pursue research in medical school, as well as unique curricular experiences that grew her passion for health equity. In her spare time, Paulina enjoys gardening, running, and hiking.

**Rachel Oldfather** is a fourth year medical student at the University of Minnesota. She is Kansas City-bound for residency training in combined Medicine and Pediatrics. Her big sister is her greatest role model in this world. In her free time, Rachel is an avid hiker, canoer, and lover of all things outdoors.

**Rebecca Grove** is a fourth year medical student who will be starting her general surgery residency at the Mayo Clinic this summer. She enjoys finding small ways to bring joy into the lives of those around her. In her spare time, she loves to read, dance, organize spaces, and propagate plants.

**Richard C. Campbell** is a fourth year medical student pursuing a career in Emergency Medicine. Inspired by his own experiences in healthcare, he is passionate about providing and promoting equitable healthcare to underserved populations. In Richard's spare time, he enjoys cooking, hiking, playing football (soccer) and volleyball.

**Sam Lorentz** is a fourth year medical student preparing to begin residency at St. Joseph's Family Medicine program. She is passionate about lifestyle medicine, mental health, LGBTQ care, environmental justice, and increasing access to wellbeing. In her spare time, she enjoys painting, hiking and campfires with friends, and cooking with her partner.

**Sowda Ahmed** is a fourth year medical student hoping to pursue a career in internal medicine with a focus on global health and health equity research. In Sowda's spare time, she enjoys reading, hiking, traveling and cooking Somali food. Her favorite travel destination is Zanzibar, Tanzania.

# COVID REFLECTIONS USING VISUAL ART

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*Back cover art by Christy Atkinson*

After spending a few intense weeks training in a St. Paul ICU over the holidays, I needed to spend some time reflecting on the experience of being within one of the world's many epicenters of COVID care. I decided to use a visual piece as a reflection tool instead of trying to process my thoughts line by line in an essay. The SARS-CoV-2 virus is invisible in its path of spread, and only when it finds a home in a human body does its wrath become tangible. I felt numb to emotion following my time in the ICU; I wanted to bring myself closer to the experience of treating COVID-19 on the frontlines by writing the words and experiences that lead patients to become sick as the air that moves into their lungs, and words spoken within the hospital by health care providers as the pulmonary structures trying to keep everything together. The circumstances that cause one to contract the coronavirus are as diverse as the people affected. Although the lies and conspiracies I have heard through the pandemic are infuriating and most definitely contributed to viral spread and increased death tolls, I needed to open myself up to the other reasons people become sick, which are often complex and nuanced without a single person to blame. Some Americans have no choice but to go to work, and they may not have the resources or support to protect themselves. Some Americans had no choice but to send their children to school or to a daycare because adding 'schoolteacher' to their list of titles was simply not possible. Others became so lonely and depressed over the year that the risk of illness was outweighed by the embrace of family. And some simply became overwhelmingly fatigued in following the rules, perhaps despair and severe economic hardship quietly contributing to their exhaustion. No matter the circumstance, people become sick and come to the ICU for care. I used the words I heard spoken by critical care providers and residents as the bronchi and bronchioles of the lungs. As the lungs became host to the coronavirus, so did our teams become host to our patients. In the end, seeing the greater picture of the rhetoric and circumstance of the pandemic, paired with the reality of caring for sick patients and the eventual death of many, I am in awe. In awe of a terrible thing we are still living.



COVID Reflections Using Visual Art by Christy Atkinson