

Old friends in nature  
Gliding away through the sky  
The fog rolling in



 **STETHOS**  
Medical Humanities Journal of CCLCM

**2022**

Cleveland Clinic Lerner College of Medicine  
of Case Western Reserve University



## Textures

August Culbert | CCLCM Class of 2026



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Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

### Front Cover Artwork

CCLCM Medical Humanities Contest, [Abdelrahman Rahmy, Class of 2024](#) | Winner (Photography)

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# DEAN'S INTRODUCTION

## ***Stethos* 2022 – A Feast of Humanities Offerings**

*Stethos* 2022 arrives in my inbox on a cold, rainy September day. The days are getting shorter and the new academic year is in full swing. I eagerly anticipate the chance to preview this latest edition, knowing it will brighten this otherwise dreary day. Previewing *Stethos* is like getting a chance to sneak into the kitchen and have a taste before a holiday feast is served. *Stethos* 2022 is a feast indeed! Beautiful reflective writing touches on themes of advocacy, listening, and loneliness. Writings on a life in medicine span the experiences of students in clinic for the first time, the “coming of age” of a resident, all the way to reflections from some of our esteemed retired Deans (yes I know the song “Maggie May” well!). We are reminded of the raw emotion of a senseless death from gun violence and the challenges of partnering with patients when there are no simple answers for their complex problems. *Stethos* includes beautiful art and photography, a reminder to stop, pause, and take in our surroundings as we go about our busy lives. *Stethos* 2022 also contains a wonderful section by the local artist, Mary Lyons.

*Stethos* is an excellent example of how we integrate the humanities at CCLCM. I keep copies in my office to share with visitors and they always come away impressed. I continue to be amazed by our students, who keep *Stethos* alive and thriving year after year despite their other busy commitments. We are deeply indebted to the Editors-in-Chief, Maleeha Ahmad and Maeve Pascoe, as well as the many Co-Editors. Thank you!

*Stethos* 2022 offers a great chance to reconnect with the humanities and the power of reflection, so central to CCLCM. Dig in to this feast, either with a nibble or full portion - you won't be disappointed.

Bud Isaacson, MD  
Executive Dean, CCLCM  
September 2022

# EDITORS' INTRODUCTION

Dear Reader,

As we prepare this twelfth issue of *Stethos* for the press and reflect on the significant challenges of the past few years, we are grateful that some semblance of normalcy has returned to our lives. In 2020, as we transitioned in and out of lockdowns, it felt uncertain that even the world's brightest minds could develop and distribute a vaccine and therapies fast enough to curb the COVID-19 pandemic. Two years later, we are fortunate enough to have had four vaccine dose rollouts. Effective antiviral treatments are widely available. Hospitalizations and death rates are low. The strains are less virulent. We are optimistic for the future.

Whether you find yourself holding a print copy or scrolling through our online archives, from the comfort of your home on a rainy day or during a quick coffee break after morning rounds, we hope this issue of *Stethos* informs, uplifts, and motivates you. This year, several pieces reflect on our theme of *enduring* - highlighting the principles and values that have endured over time and periods of change - as we celebrate the 100th anniversary of the Cleveland Clinic but also mark two years of the pandemic that has profoundly impacted our lives. Within these pages, you will find contributions from our students, residents, fellows, attendings, and spiritual care practitioners that capture a vast collection of experiences, ranging from the reflections of a "blindfolded" first-year medical student crowding the doorway to those of an experienced clinician looking back on a lifetime of meaningful relationships. Additionally, we are pleased to feature a talented local artist, Mary Lyons, whose beautiful and thought-provoking pieces inspire us all to find the creativity within ourselves.

Finally, we express our sincere thanks to you, our readers and contributors. None of this would be possible without your continued support. We hope you enjoy this latest issue of *Stethos*.

All the best,  
The Editors



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## Take a Breath

Ava Fan | CCLCM Class of 2025

Just a reminder to take a pause and breathe every once in a while.

# On Advocacy

Lilian White, MD

What does it mean to speak up?  
And what does it mean to speak loud?  
Sometimes it feels like a dial turned up: I am loud.  
Then flip, the dial turns down.  
I observe. I am quiet.  
How do I decide when to turn it up again?  
Do I need to be loud to show I care?  
Maybe I care, then I am loud.  
I am loud when I care.

As a new physician, I am growing more and more to appreciate the importance of our role as advocates for our patients. Those two letters now boldly added after my name are a privilege and weighted with responsibility. Part of that responsibility is as an advocate for my patients.

As a medical student, the term “advocacy” for me was associated with protests and waving signs outside the state house and speeches on the floor of legislatures. As a generally quiet person with a tendency towards small gatherings, any thought of getting involved in “advocacy” quickly had me going in the opposite direction.

As a resident physician, I have discovered power in being an advocate for my patients – to nursing staff, to other physicians, to consultants, to insurance companies. Our role is to care for the patient putting their trust in us. I have found a great amount of professional satisfaction in standing up for what I believe is best for my patient. Being an “advocate” has allowed me to bring the big, uncomfortable concept of “advocacy” to a more personal, attainable level.

As I have begun to embrace being an advocate, I have discovered over the past year that my love of words and my passion for caring for patients dovetail to create my chosen form of advocacy: writing. When I write, I thoughtfully select my themes, I choose my words with precision, and I edit for clarity – all of which provide me with a sense of directed purpose in my advocacy.

I have found as a physician, more and more people are listening when I speak – or more accurately, write. Words are power for change – and can be used to improve the community around us. I have come to appreciate the role of physician-advocate, embracing, and developing my own approach to advocacy through writing.



## Hospital in Harmony

Joan Nambuba, MD, MS | CCLCM Class of 2022

If you listen close enough  
The hospital has its sounds  
If you listen close enough  
You'll hear the sounds everywhere  
Like the slow trickle of rain into a plastic red bucket  
Drip drop, the sound of reagent against your sample  
Drip drop, the sound of your inpatients' continuous IVs  
Drip drop, the sound of leftover coffee into your reusable cup  
If you listen close enough  
You'll hear the sounds everywhere  
Like the quick splash of yellow boots hitting a puddle

Swish swosh, the sound of betadine on your marked site  
Swish swosh, the sound of apple juice on your patients' trays  
Swish swosh, the sound of your damp socks against your shoes  
The hospital has its sounds  
If you listen close enough  
Drip drop, the sounds follow you  
Swish swosh, let the harmony reign

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## A Donor's Gift

Mihika Thapliyal | CCLCM Class of 2025

when I sit by the fire,  
does the warmth fill your chest?  
whose breath is taken away,  
when I see the northern sky at its best?  
tell me, how does the crisp winter air  
feel beneath the trees?  
and if I sit completely still,  
do I breathe for you,  
or do you for me?

-you gave me your lungs



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**Discover**

Roma Raj, MD

In this fast-paced and loud world, it is a luxury to find time to rediscover yourself.

## Alone Together

Will Patterson | CCLCM Class of 2025

I've never met the girl next door. I know  
she's in there — DoorDash-ed McDonalds sits wafting  
sweet fumes under my door. The wick  
flicker of a candle her porch window trades for night.

I think she's in healthcare, since once I saw  
Scrubs, powder blue, drying in our hall.  
And a dirty mask tucked under the doormat.  
Healthcare heroes live there.

She can't be big, I'm guessing  
by her shoes. Not in love,  
They say—she seems to live alone.

We're twins in that regard,  
Two people alone, together at home.  
Bearing out the storm that hails  
Of sirens and sickness and sadness.  
I eat

My dinner (ham sandwich) hunched over the sink  
And wonder. Why haven't we at least  
Mumbled a gruff hello or masked  
A smile? Why the candles? I'd like

To meet her, someday—  
Outside, without masks or scrubs.  
I'd talk like candlelight, I'd sing the blues.  
Thoughts burn quick, I can't

Imagine more. Winter is too long.  
The snow extinguishes the highway and  
blankets me in chills — I sound alone.  
But just like winter, this too shall pass.

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## “It’s Not Your Thyroid”

Michelle Lundholm, MD

I steady myself before knocking on the exam room door. The face sheet confirms that my 10 o'clock waits on the other side. She is a 25-year-old woman who is here for another opinion.

“Hello!” I enter cheerily, doing my best to radiate warmth on an otherwise chilly spring day, “My name is Dr. Lundholm. You must be Ms. Peters. Is this your first time to our endocrinology clinic?” She affirms with a nod.

While crossing the room to take my seat, I observe details that won't be documented in any physical exam. She wears Lululemon athleisure attire, her hair is neatly kept, and her fingers are manicured a faint pastel pink. She introduces herself softly, as if the full volume of her voice might summon tears. There is not one, but two Samsung devices at the ready in case she needs to phone a friend. Out from her Gucci bag pokes a color-coded binder full of printed medical webpages. I catch myself squinting for a fraction of a second, but resign that I can't make out the exposed URLs from my chair. Without missing a beat, I continue, “In that case, welcome! What are we here to talk about today?”

## “It’s Not Your Thyroid” contd.

I ask the question every time, as if I don’t already know the answer. This isn’t just a second opinion – it’s a fourth. My note pulls up on the screen, half-populated from a detailed review of outside records. It took an act of restraint last night to keep from filling in the subjective parts of the HPI prematurely. I like to come in prepared, sometimes to a fault.

She launches into a familiar narrative, and I type along. . . She has not felt like herself in a couple of years. Before the pandemic, she was a different person: she was bright and bubbly, she never struggled to get out of bed, and she enjoyed Zumba and Pilates workouts most days of the week. As of late, she has grown increasingly tired and irritable. She has noticed her hair falling out more in the shower. She doesn’t have the energy to work out anymore, and she doesn’t appreciate the added 15 pounds on her waistline. She feels weak, both physically, and in fortitude. She has emptied the shelves of a GNC and nothing has helped. She has seen every doctor, had every blood test, and heard every excuse. Every family, friend, and website has told her that it must be the thyroid; every endocrinologist has told her it is not. She knows her body, and she is certain that there is something chemically, hormonally, deeply wrong with it and she is frustrated no one can tell her why. I sink imperceptibly in my stool under the weight of her unmet expectations.

She continues to an anecdote about how her fatigue ruined an interview last month, and I suppress the urge to interrupt. Glaring at me from the computer screen are years of perfect thyroid lab values, even as recent as last week. Her TSH has impressively and consistently ranged 1.4-1.8 with an equally healthy Free T4. I review the results from past opinions, composed of community and academic doctors across the country. One overly zealous endocrinologist checked every hormone that money can order. I scroll through an overwhelming and unnecessary list: cortisol, prolactin, growth hormone,

reverse T3, estradiol. . . it goes on. By deduction, there is no endocrine investigation left for me to offer.

But I can offer her my attention, so I listen. We go over a few more of her symptoms (nonspecific), historical items and examination (nonrevealing), and thyroid interferences (nonapplicable). Once satisfied with my understanding, I offer one last open-ended question: “Is there anything I haven’t asked about that you would like to share with me?” Her eyes drift upward and her forehead furrows with consternation as she ponders this for a moment. She plays our conversation back in her head for any missed points or lines. After a pause, and for the first time all appointment, she genuinely smiles. Optimism rings in her voice as she replies, “No, you got everything.”

I bask briefly in that sunny moment because the stormy-blue Kleenex box in the corner of my vision reminds me that there is turbulence ahead. My computer screen is swiveled in her direction and her lab results are queued up for review. What does she understand about this test? What about that one? I explain, interpret, swipe to the next, and repeat. Suspense forms as we save the thyroid for last.

“And finally, let’s look at the TSH and the Free T4.” As I speak the words, she tenses, crossing her legs ever-tighter, and leans in. “These two levels help us gauge the function of the thyroid. They act as a see-saw, when one goes up the other goes down, and vice-versa. Yours are. . .” I linger momentarily, triple-checking myself in real time, “Undisputedly normal. Perfect, actually. And by the looks of it, have been that way consistently. With these levels, we cannot attribute your symptoms to the thyroid. I’m sorry that this wasn’t the solution you hoped for.”

As if on cue, the tears well up as she translates my message: It’s not your thyroid. I hand her a tissue to blot

## “It’s Not Your Thyroid” contd.

at reddened, darkening eyes. I can tell she is processing so we sit in silence. The room is so quiet I can hear my pulse in my ears. I count to about 20 beats before breaking the tension.

“I understand that this has been very frustrating. I wish we could blame all this on the thyroid, because that would be an easy fix. But thyroid medication, if given unnecessarily, causes more harm than good.”

Her head bobs in understanding but she averts her eyes to stare at the moist tissue in her hand. Her brow creases as she considers me and my message. Is she accepting this news? Have I done enough to build my case or—more importantly—her trust?

These conversations always burn a pit in my stomach. I answered the call to medicine because I wanted to provide answers for our patients. Yet, too often, I’m tasked with the role of taking them away. I know that I am not alone in feeling this way because most of us in healthcare, regardless of our specialty, participate in these encounters with some regularity. I consider myself lucky that on this particular day, in this particular case, the results are unambiguous and there are no endocrine tests left to order. But without these conditions, saying “no” becomes even more of a challenge. From experience in varied settings throughout the course of my training, I appreciate how fortunate we are here that our advice often wields a little extra weight by virtue of our connection to this successful and well-known institution.

In that moment, I am hanging on the silence, hoping that maybe, just maybe, this can break the cycle of second opinions and get Ms. Peters back on track.

Eventually, she confesses, “I don’t know where to go from here.” Her vulnerability offers promise that she is open to redirection. I adjust my screen back to its normal configuration, and I turn to her. This time we maintain our eye contact.

“Just because we have not found an answer today does not mean that there is not an answer, nor that you should stop searching. There is no endocrine treatment, but maybe there is another type of medication or intervention—outside of my area of expertise—that you could try. I know you’ve seen a few doctors before me. . . have they offered any other thoughts or suggestions so far?” I probe her for alternative considerations, knowing that the best next step has likely been proffered along the way.

“My primary care doc mentioned we could try an antidepressant. I hoped thyroid medicine would help, since I don’t like the idea of being on antidepressants. But I guess now that the thyroid is off the table, I could revisit the discussion with her.” She sighs. Inside, I sigh too. It’s frustrating to hear persistent stigma surrounding antidepressant medication. Too often it seems that the people who could benefit the most from these medications are also the ones most hesitant to try.

“I think that is a very reasonable next step. Would you like me to send our office note to your PCP so that she knows what all we’ve talked about today?” She waited a month for this appointment and came from 3 states away; sending along the message to her PCP seems like the least I can do.

“Sure,” she shrugs. In the moment she is hard to read.

I take the opportunity to step out and staff. “I’ll be right back,” I promise her. Sure enough, my attending and I return in a few short minutes. We are a united front; he reiterates that there is no other way to interpret her bloodwork. In the time it takes me to print the after-visit summary, he has already wafted in and back out of her room. Alone again with Ms. Peters, I hand her the papers which she dutifully adds to her color-coded binder. She gathers her belongings and rises to follow as I lean into the frame to prop open the exam room door for us both.

## “It’s Not Your Thyroid” contd.

She catches me by surprise with a, “Thank you,” spoken sincerely and appreciatively, “for being so thorough and hearing me.” I never expect any expression of gratitude, especially after delivering difficult news. This gives me renewed hope that I have accomplished something for her in our time together.

We always have something to offer, even if it is not The Answer.

Someone might tell you that the endocrinologist’s role is to diagnose or rule out endocrine disease. On paper it is. But many times, the labs have been drawn and the diagnoses excluded long before the patient sees us. Rather, we’re the ones who deliver the news gently. Only by definitively closing those options can they be more open and ready to take their next steps, bringing them closer to finding the most appropriate treatment.

I usher her into the hallway and hear the click of the handle closing behind us. We steer through the maze of corridors back to reception where we express customary well-wishes and nods of goodbye. The double doors out of the endocrinology division and into the waiting world lie open ahead. I watch as she passes through without looking back.

The face sheet for my 11 o’clock appointment waits on the counter. “Ms. Robertson,” I call into the waiting room. A tall, dark-haired, young slender woman stands in acknowledgement.

“Nice to meet you, my name is Dr. Lundholm. Come on back, we’ll be right this way.” We re-enter the web of clinic rooms. “We’ll be right here in room 13,” I gesture her into the exam space with a sweep of my arm. She settles into the chair and pulls out a folder full of doctor’s summaries.

“Welcome to the endocrinology clinic. What bring you in today?” I open. She ruffles her papers, and launches into her list of symptoms. I try my best not to interrupt. Just like that, the cycle begins again.

***The events described in this vignette are an amalgamation of many encounters. All details have been altered to protect patient privacy.***



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## Above the Clouds

August Culbert | CCLCM Class of 2026  
Big Bend National Park, Texas

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## Snowfall at Forest Hills Cemetery

Miranda Arakelian | CCLCM Class of 2026

Each day during the first year of the pandemic, I would sneak through a (well-known, since-patched) hole in the metal fence of the cemetery near my house. I walked before work, at lunch, after work - whenever I could. In a time period of flux and a lot of “unprecedented” everything, the cemetery was my tranquil sanctuary. The gravestones stood in contrast to these majestic trees, who, decade after decade, endure.

## Knowing When to Let Go

Nandan Kodur | CCLCM Class of 2026

While working in a hospital in upstate New York during his third year of residency in 2012, my longitudinal clinic preceptor, Dr. D, admitted a ninety-two-year-old Ukrainian man with congestive heart failure. The patient, named Bodhan, had extreme fatigue, shortness of breath, and generalized edema. He had a pacemaker and a defibrillator, both of which were firing constantly.

Dr. D initially employed an aggressive treatment approach, in no small part because Dr. D had become close with Bodhan and his family. Bodhan's son, two daughters, and wife of over sixty years visited Bodhan in the hospital regularly, and Dr. D had grown fond of them. They were a kind family, and they desperately wanted Dr. D to do everything within his power to prolong Bodhan's life. So that is exactly what Dr. D did. He ran countless tests, requested numerous cardiology consults, and maxed out Bodhan on diuretics and other medications.

Despite Dr. D's best efforts, Bodhan's condition continued to deteriorate, and it became clear that an aggressive treatment approach was futile; Bodhan likely had end-stage heart failure and there was little that could be done. Still, Dr. D struggled to curtail treatment because he did not want to fail Bodhan and his family. In Dr. D's mind, persistence was the only option.

But then Dr. D received some sage advice from his department chair: a physician should know not only when to persist, but also when to relent and let go. Though this was a hard pill to swallow for Dr. D, he realized it was true. And after mulling over Bodhan's condition and prognosis, Dr. D spoke with Bodhan's wife and explained the situation to her. She was heartbroken, and initially resisted giving up on her husband—her life partner of over sixty years, whom she had spent every day with since her 20s. But as reality dawned on her and she considered her husband's suffering, she agreed that

it would be best to stop all treatment, including her husband's defibrillator. Soon after, Bodhan passed away. And Bodhan's family, rather than being disappointed with Dr. D, thanked him for being transparent and allowing Bodhan to avoid needless suffering.

As I listened to Dr. D share this story about Bodhan with me, I could not help but think about how I would have reacted had I been in Dr. D's shoes. Like Dr. D, I would have initially struggled to relent and let go — to give up on a person's life, someone who was also a husband and father. My gut reaction would have been to exhaust all possible treatment options and then some, just to know I had done everything in my power to buy Bodhan a few extra moments with his family. Likewise, I would have strived to remain optimistic when discussing Bodhan's condition with his wife, to avoid extinguishing her flame of hope. Upon reflecting on the situation for some time, however, I too would have come to grips with reality and relented — not because I was giving up on Bodhan but because I was letting him go. After all, there is no shame in succumbing to death, an inherent part of life.





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## Connections

[Maeve Pascoe](#) | CCLCM Class of 2024

Winner (Artwork), CCLCM Medical Humanities Contest

This picture is not one, but two images; the background is a photo, the foreground is an illustration. The background is a confocal microscopy image of the corpus callosum, stained for its many cellular components, created as part of research to understand how those components and their interactions can bring about disease states such as multiple sclerosis. However, the corpus callosum itself is beautiful in its simplicity; it is what allows for connections across brain hemispheres, and what inspired the foreground of this picture. The illustration in the foreground is of two people, connected to each other, standing on a precipice above the sea, witnessing the beauty of the expansive universe. The microcosm of the brain and the macrocosm of the universe are not all that different, and in the end, it is our connections, between our cells and between ourselves, that give our experience of the world meaning.

# Hall of Mirrors

Richard Prayson, MD

Each day we awaken from our slumbers  
and open our eyes  
to meet what lies ahead.

And we move ourselves  
from our known comfort  
to venture into a hall of mirrors.

The reflective walls surround us as we set forth.  
The hall's way twists and turns,  
lined by glass straight and curved.

We think we know ourselves so well,  
familiar with our visage  
as we know it to be.

Or, as we see it  
reflected along the way,  
but the truths are distorted as we move.

And for the others we meet along that way,  
their appearances are noticed  
as they appear on the glass.

All appearances given back from whence they came,  
not quite the same as is,  
as is real or imagined.

Sometimes larger  
as they loom,  
hoping in ego's desperations to be noticed,  
for they bind their worth to being seen  
as looming and thereby important  
feeling empowered in some way.

Sometimes smaller  
as they hide,  
for they do not wish to be seen,  
embarrassed by who they are and how they look  
wishing they had not ventured out at all  
into a world where they are not seen.

Sometimes wider  
as they appear to rest  
in the comfort of what they own and possess,  
for they believe that such things  
make them happy and of worth,  
to those who can see it all.

Sometimes thinner  
as they appear like a line,  
moving quickly as they dodge and evade  
what comes at them,  
for they have not the strength or wish  
to own or be responsible for what may come.

Sometimes twisted  
as they are pulled and pushed  
by what finds them,  
uncertain which way to go or move  
or what to believe or not,  
indecisively turning to and fro.

Sometimes shattered  
as pieces broken and unconnected,  
seem to move in random ways  
without design or purpose,  
fractured,  
splintered.

Sometimes one's impressions of what are,  
without distortions as intended,  
are what they seem to be,  
but what resides behind the reflections,  
are oft hard to know with certainty.

And so, through the hall we make our ways,  
each day as we move and be,  
catching glimpses of reflections myriad,  
of those we meet and of ourselves.

For some reflections are what is,  
as they guide where we move and how we act.  
And others are what seem to be,  
distracting and deceiving.  
For at the day's end,  
as we prepare to rest and close our eyes,  
we can sometimes see more clearly,  
what is real and what lies beyond the reflections  
that seem to be.

## How Much Time Left?

Arsal Tharwani, MD

How much time left?

Do you say this to trigger a reaction?

I refuse to believe we can't take any action,

We came to hope,

We left with despair

Do you believe in miracles?

Do you believe in God?

My loved one is at your mercy,

Lie to me

that we have options

Alas! Your eyes don't lie,

I have come to acceptance,

You fought a battle already lost,

for that, I forgive you

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## Peering Through

My two-year pandemic journey from Emergency Medicine staff to Palliative Medicine fellow

Candice Leigh, MD

Called to triage	Called to MICU
I was told he walked in	I was told time was short
A lacey purple hue	Cradled in bed
Breathless with words	Her peaceful gaze
I hear alarms, my heartbeat	A Stillness
Is it here?	It has changed us
Seconds feel like hours	I stand outside the small ICU room
Donning plastic	Looking at her
Supplies are ready	Sisters, brothers, children around her
My team stands outside the vast resus bay	Eyes heavy behind foggy face shields
Peering in through the glass	Warmth emanates
Looking at him	I called them here
I called them here	It is time
It is time	They sit inside
He rests on the cot	Peering out through the glass
Looking at us	Looking at me
Alone	Alone

## Eyes

Roger B. Murayi, MD

As I frantically searched the operating room for hair clippers, I glanced back at my attending standing in a pool of fresh blood while holding the head of our patient. It was 2am on a Saturday and we were prepping for an emergency craniotomy for a young man who had been shot in the head. His prognosis was poor, but he was young, and his identity and family unknown. I found the clippers tucked away behind the computer then hurried back to the OR table to shave the patient's head. The room was buzzing with different teams working to prep for surgery.

Our patient lay unconscious on the operating room table, arms sprawled out to either side as if on a cross as anesthesia worked to prep the arms and we worked to prep the head. The overhead OR lights radiated down illuminating his white hospital gown tainted with blood. Puddles of bright red collected around his head, seeping out from underneath the saturated gauze my attending held to his head. As I shaved off the patient's foot-long dreadlocks matted in a congealed red, I thought about how long it must have taken him to grow them to this length. Years of slow, steady growth with the hair entangling itself into longer and longer dreads; all cut short in an instant as we prepped for surgery. I wondered if he would ever get the chance to grow them back.

Within minutes, the right half of our patient's skull was removed, and a large blood clot evacuated. We inspected the surface of the brain for any signs of active bleeding. The yellowish-tan gyrations of his brain glistened in the spotlight of the OR lights. We watched as the brain slowly started swelling and we knew it was time to close as quickly as possible. Leaving the bone flap off, we raced to suture closed the muscle and skin over the rapidly swelling brain. When everything was fully closed, we removed the blue drapes covering his

body, prepped his hospital bed, and patiently waited to bring the patient up to the trauma ICU. We had done all that we could. The rest was up to our patient's body and medical management of swelling.

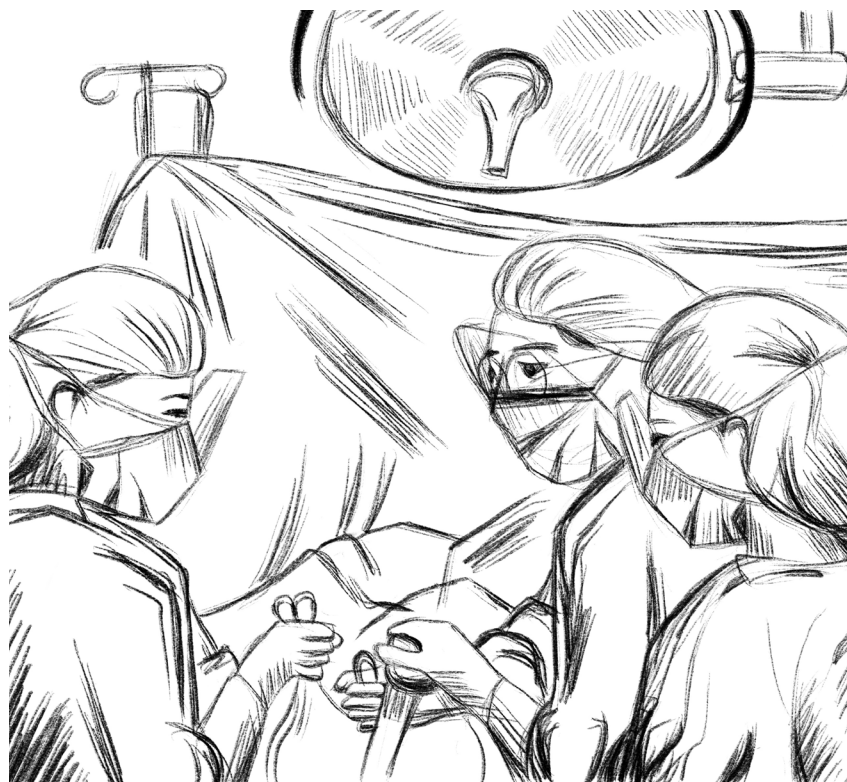
I grabbed my penlight and standing over his head, gently pulled back his eyelids and shined my light into his pupils. "Come on, buddy. Come on," I caught myself mumbling under my breath. Over and over, I shined my light into his eyes, closed them for a second, and then opened them to try again. His pupils were non-reactive, an ominous sign of brainstem damage. We knew he was unlikely to do well before we started, but we had to give him a chance. I closed his eyes once more, put down my penlight, and took stock of the young man sprawled out before me on the OR table. The OR lights, still on, shone brightly off his dark brown skin and slight frame with tattoos scrawled across his chest. He couldn't have been more than 20 years old; a teenager with a bullet in his head. Written in bold face font, arcing across his upper abdomen, a tattoo read, "Lord, protect me from my friends, for I can handle my enemies."

I wondered about his life. I wondered about his name, his family, his "friends", and how he was shot in the head. It was all unknown as he was found down by EMS after a 9-1-1 call following gunshots. His chart in the electronic medical record had his first name as "BlackMale" and last name "Unknown." His date of birth defaulted to January 1, 1900, calculating his age as 120 years old. I watched his chest as it rose and fell with the ventilator, his tattooed brown skin the same tone as my own. I helped push his bed up to the trauma ICU, gave a grim report to the ICU team, then lifted his eyelids one more time to shine my penlight. Still non-reactive.

We never figured out the identity of our patient. He died a couple days later still listed as 120 years old. I think about him from time to time; about his young face, lifeless eyes, and brown skin. I think about the countless Black patients I helped take care of, victims of gun violence and poverty. I think about our neurosurgery department pictures – mine the only Black face for years. I think about my neighborhood where I bought a house early in residency. All the black faces coming and going in my neighborhood. I think about the white nurse practitioner who remarked that I was “brave” for buying a house in that neighborhood. I think

about the crime statistics I looked up before buying it that were no different from the similarly urban but whiter west side of town. But none of that matters.

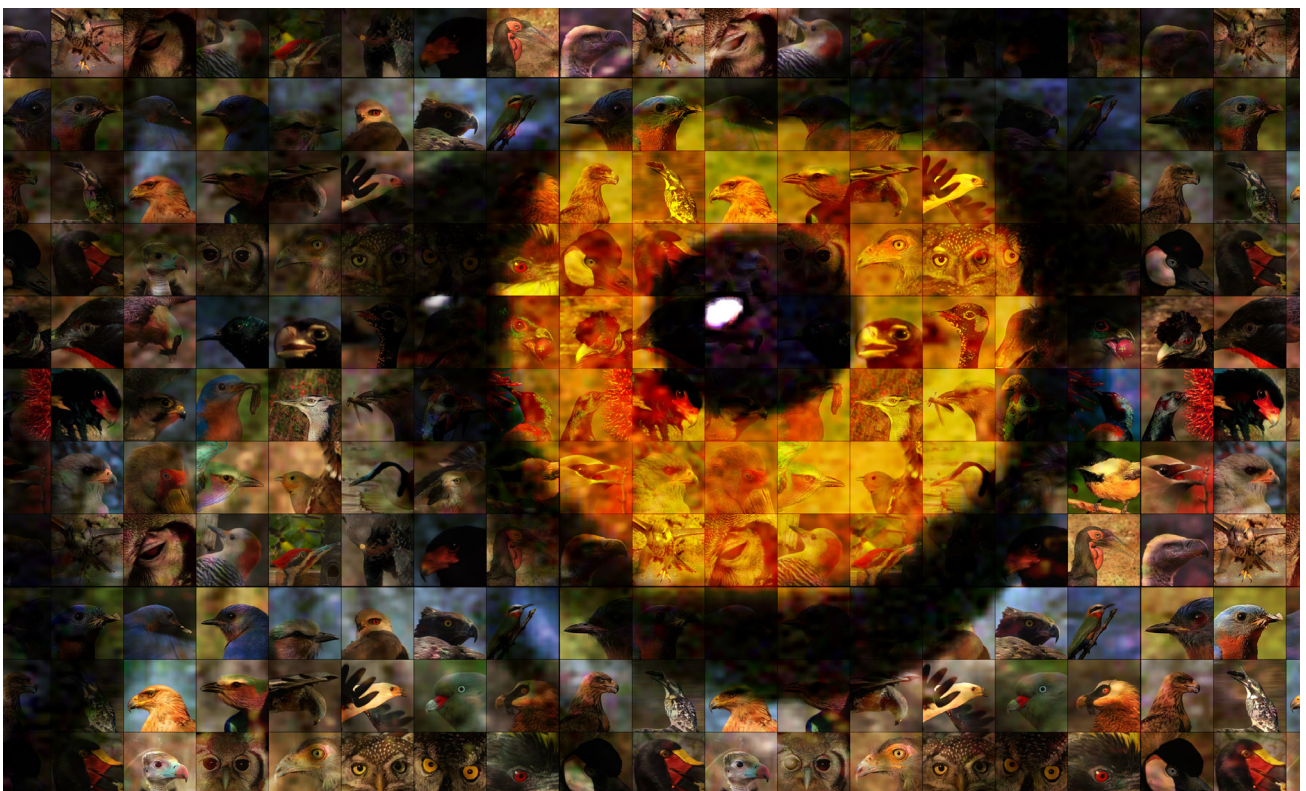
I think about the unknown BlackMales and unknown BlackFemales laying invisible right next to one of the greatest hospitals in the world. Quietly tucked away behind years of hyper-segregation and income inequality in the city of Cleveland. But most of all, I think about shining a light in his eyes over and over again, hoping he’ll be seen and maybe even see again.



## The Attending, the Resident, and the Medical Student

Lianne Mulvihill | CWRU SOM Class of 2024

A quick sketch drawn between OR cases on my surgery rotation. When I think of values that have endured over time in medicine, I think of mentorship. We often talk about medicine as a lifelong learning endeavor, but with learning there is also teaching. I’m so inspired by all the physicians who take time to teach students... you’re all amazing!



**The Eyes are the Windows into the Health of All**  
Lars G. Svensson, MD, PhD

## I Thought I was Ready

Radhika Duggal | CCLCM Class of 2025

I always considered myself to be comfortable with the idea of death – at the very least, more than the average person. I partially attributed this to the fact that I have engaged in countless conversations about death. Not only have I had these conversations in a casual setting with my friends and loved ones, but I have also broken apart the idea of death and approached it from different perspectives in the setting of my previous academic work in bioethics. However, none of those conversations could have prepared me to feel the weight of death's imminence in a patient encounter.

I was shadowing in gynecologic oncology a month ago and was pleasantly surprised at the fast-paced, positive energy of the session. Nearly every 10 minutes, my preceptor and I would walk into a patient room, perform a pap smear, and the patient would reminisce about their (now resolved) history with cancer with my preceptor. After gathering any updates and making small talk, my preceptor would wish them well and we'd see the next patient.

It wasn't until one of the last patients of the day that the atmosphere changed. It was clear as soon as we walked into the room that this would be a different encounter. While the previous patients sat back, almost relaxed, in their chairs, this patient was at the edge of her seat. She was accompanied by two individuals with equally solemn appearances. Both of these family members had padfolios that appeared to be well worn, almost overflowing with papers that had small notes written in the margin.

After my preceptor introduced himself, the patient and her family stated that they had traveled from out-of-state to see my preceptor specifically for a second opinion, as he is among the best in his field. The patient's husband shuffled through his padfolio as he provided his wife's history. I noted that he paused at certain words, sounding

them out and using phrases such as “they called it a \_\_\_.” It seemed as though he didn't know what some of the words meant, but was undoubtedly doing his best to record and understand the course of his wife's illness.

At the conclusion of the summary, the patient's sister-in-law asked, “do you agree that this is a stage IV endometrial cancer? That's what her previous doctor said, but we don't know.” My preceptor responded that endometrial cancer is graded by its spread. He shared that unfortunately, many of her symptoms, such as rectal bleeding and pleural effusion, aligned with possible metastatic spread. Though he would need her previous imaging to make a definitive statement, her “enlarged groin nodes” and “palpable abdominal mass” were not good signs. I noted that throughout the conversation, the patient's family would alternate between giving me a confused look, making eye contact with my preceptor, and quickly jotting things down in their padfolio. When my preceptor picked up on this, he momentarily excused himself to grab an information sheet regarding cancer staging.

During this time, the patient's husband and sister-in-law looked at me and asked “[Preceptor] keeps mentioning ‘enlarged groin nodes’ – what are these?” While my preceptor was still gone, I explained that he was saying “groin nodes” and referring to the lymph nodes in her groin area – the round, enlarged areas we were examining on the patient earlier. I was surprised at how visibly their faces changed – a few wrinkles on their forehead relaxed as they became just a little less confused. Then, they asked me what these lymph nodes meant in terms of her diagnosis and I explained that my preceptor was bringing a handout to show how these enlarged lymph nodes can play a role in determining the stage of a cancer.

## I Thought I Was Ready contd.

When my preceptor returned, this back and forth with the family went on for some time. I did, unlike before, respectfully chime in when the family looked confused to suggest to my preceptor that a particular phrase might need explaining.

Ultimately, my preceptor stated that we would need to wait for her previous imaging to be transferred and for a thoracentesis to be performed in order to determine the extent of the spread and develop a plan. The patient's husband stated that they were all willing to stay in a hotel as long as they needed to follow up and asked if there was any way for the thoracentesis to be done that day (at this point, it was already past 4pm). I will never forget the almost overwhelming and tense emotions of fear, anxiety, love, and sadness in that room.

My preceptor prepared to perform a thoracentesis in the clinic. While I closed the patient's curtain so she could change, I found myself alone with her husband and sister-in-law. "I don't know how you do this", her husband said, "I'm a computer engineer and you make that look easy. I don't understand half these words. Thank you for explaining some of them to me." I barely remember my response to him. I know I tried to say something reassuring like "of course, I couldn't imagine what you're going through," but I was overcome with emotion at that point. We have practiced countless ways to express empathy throughout our training, but nothing I could say felt like enough. Words couldn't begin to do justice to the level of pain he must have been experiencing.

What was scheduled as a 20-minute visit ended up being almost 2 hours of face-to-face patient time.

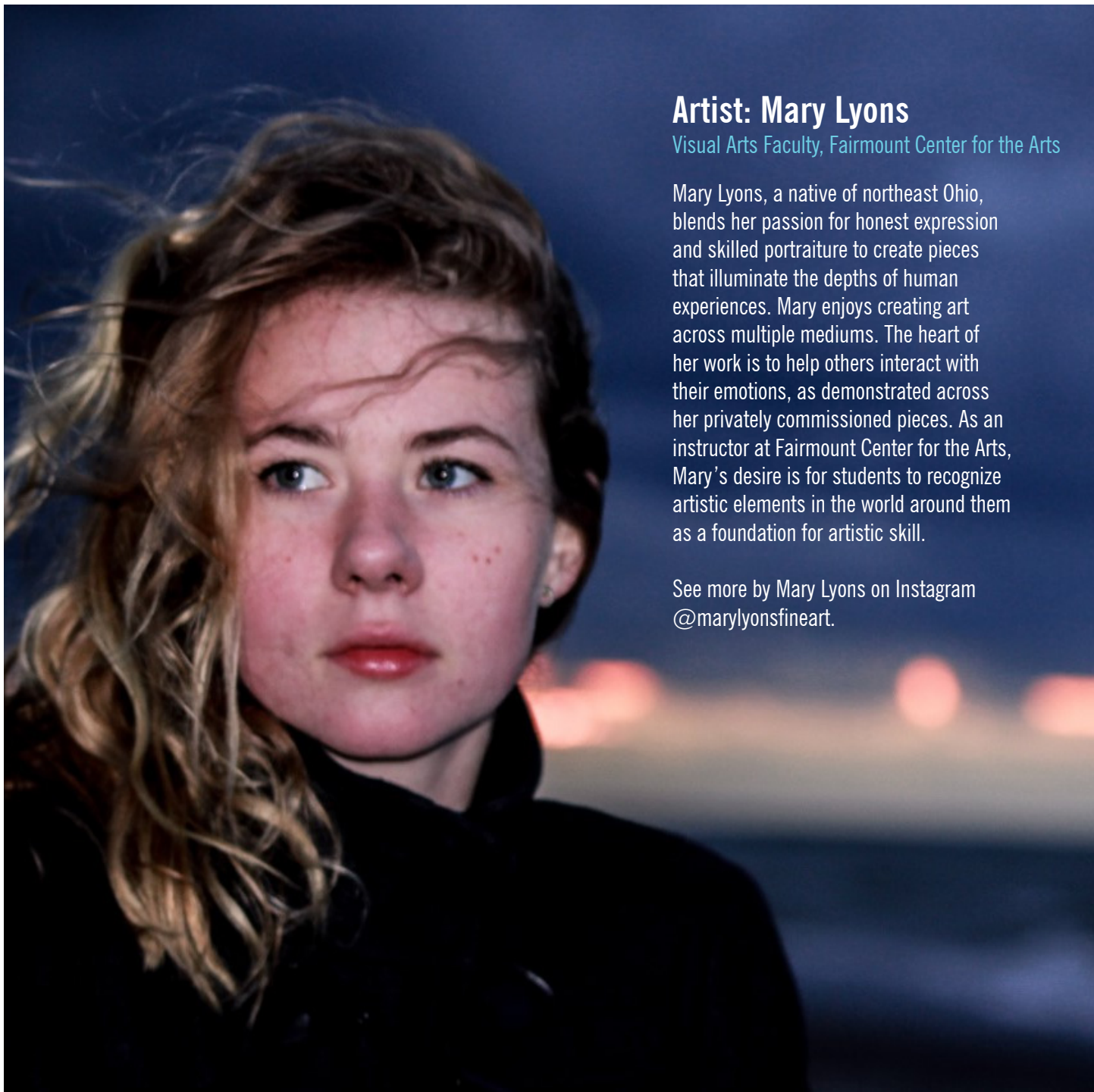
There are very few days I don't think about how she is doing. I think about her husband and sister-in-law jotting notes down in their padfolios, the confused looks they shared, and the times when the patient would gently grab her husband's hand and give it a tight squeeze – usually after she noticed his leg started shaking. I specifically remember the patient's husband privately asking my preceptor, while the patient was in the restroom, how long she had to live. I saw the emotions leave his face as my preceptor explained a graph on his computer that stated only 20% of patients with her extent of illness survive for one year. When the patient walked back into the room, her husband cleared his face and gave her a reassuring smile – as though he hadn't just heard that devastating information.

I actually have not yet experienced the death of a close loved one myself. I now know that I might be comfortable with the abstract notion of death, but I'm not comfortable with it as a realistic possibility. Frankly, my false belief that I was comfortable with death probably stems from the fact that I haven't had a serious encounter with it. Even now, I am sure I only feel a fraction of what the patient's family does – and it still feels like an overwhelming amount of emotions.

As much as I consider this to be a pivotal moment for myself and my growth, I have to remember that this story isn't mine in the same way as it is the patient's and her family's. Nonetheless, despite only having met this patient once, I will never forget the impact of being in that room with her. Moving forward, perhaps I cannot ever truly be ready for a difficult patient encounter, but surely each experience like this will add a new dimension to my ability to support future patients.



# FEATURED ARTIST



## Artist: Mary Lyons

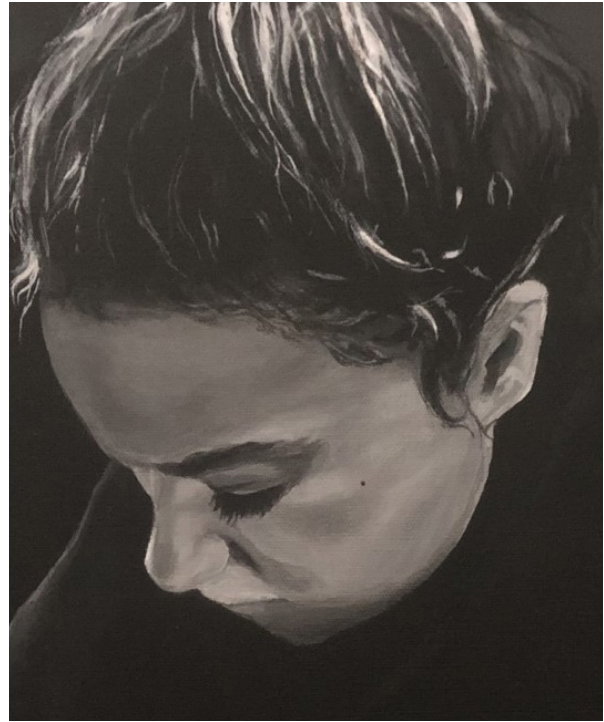
Visual Arts Faculty, Fairmount Center for the Arts

Mary Lyons, a native of northeast Ohio, blends her passion for honest expression and skilled portraiture to create pieces that illuminate the depths of human experiences. Mary enjoys creating art across multiple mediums. The heart of her work is to help others interact with their emotions, as demonstrated across her privately commissioned pieces. As an instructor at Fairmount Center for the Arts, Mary's desire is for students to recognize artistic elements in the world around them as a foundation for artistic skill.

See more by Mary Lyons on Instagram  
[@marylyonsfineart](https://www.instagram.com/marylyonsfineart).



**Love Knows No Age**



**Introspection**



**Look to the Son**



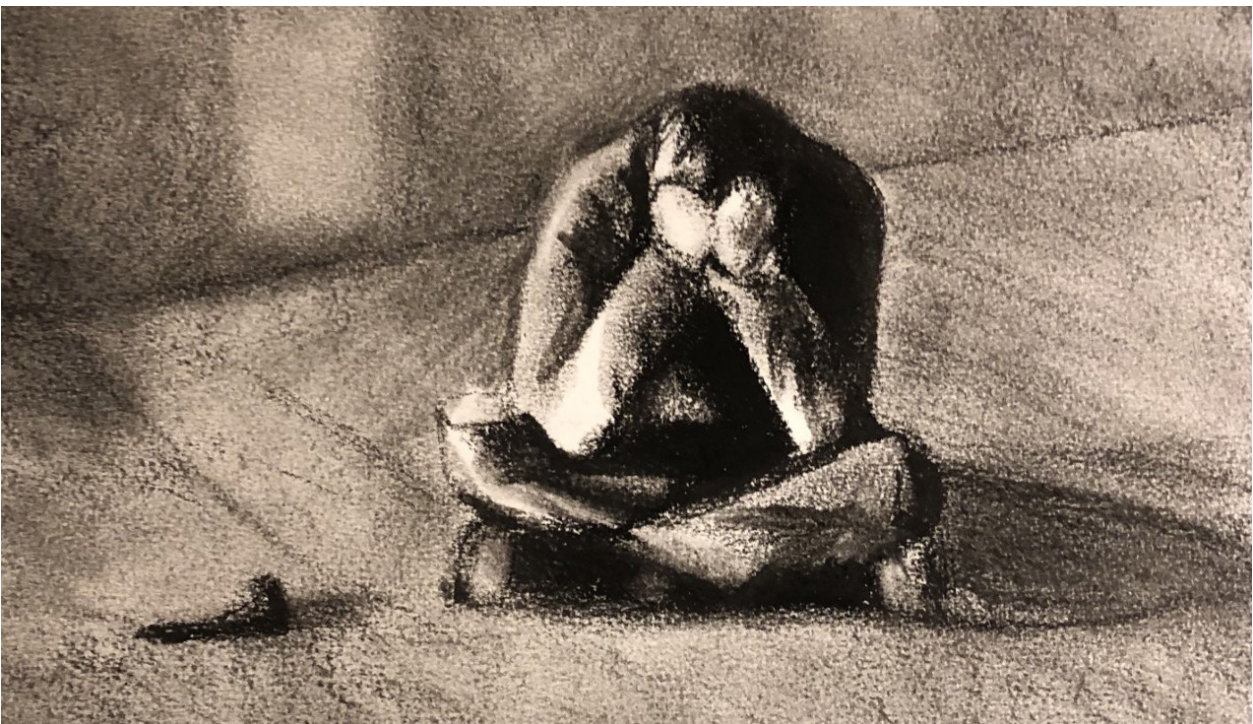
**Beautiful Souls**



**Keep Swimming**



**Almost Home**



**There is Hope**

## Humble Medicine

Chineme Onwubueke, BS | CCLCM Class of 2025  
Winner (Prose), CCLCM Medical Humanities Contest

“I don’t think mass vaccinations should be required,”  
Aunty Chioma said. I sighed.

I had just finished my first year of medical school and was visiting family as I always do. June’s warmth found a home in our 2-story house. I leaned against the peach-colored wall with my arms crossed over my chest as Aunty Chioma – or more simply “Aunty” – stirred something on the stove. The sweet smell of fried plantains and Nigerian spices from the night before still clung to the kitchen curtains that swayed with the wind behind Aunty.

I was so excited to be staying with her and the family for the week. But I wasn’t so excited to be having a conversation about vaccinations...again.

“It’s true,” she started again, “I just don’t think it should be forced upon people.”

I shifted my weight on the wooden floor as I opened my mouth to answer, pulling on one of my favorite public health factoids.

“But mass vaccinations are how we’ve been able to end diseases and epidemics from the past, like polio and smallpox. And they wouldn’t have worked if nearly everyone didn’t get vaccinated.”

“I know,” she responded, nodding her head without looking up, “but this vaccine doesn’t have that degree of effectiveness. Though I would be reluctant, I’d be more willing to say mandate it if it actually stopped transmission. The one thing we know it does is reduce the severity of infection and reduce one’s chance of being hospitalized. This we’ve seen.”

As a nurse practitioner at a nearby hospital, she knew firsthand that COVID-19 patients in the ICU were disproportionately unvaccinated.

“But I don’t think that something that mainly protects yourself should be mandated,” she continued. “You know Uncle Peter is unvaccinated?” she said, turning her face to lock her ebony eyes with mine.

The corner of my lips turned down.

“He’s been using alternative remedies instead.”

I swallowed, working hard to maintain my poker face. My body went tense immediately, but I breathed in deeply to still my nerves.

“Also, have you heard of ivermectin?” she continued.

“Uh yes...kind of...a little.”

“I’ve heard it’s been shown to have some effectiveness in treating COVID-19.”

“Hmph,” I grunted with an unconvincing nod.

“No, it’s true,” she continued, returning her eyes to her pot. “I will send you some studies so that you can look at them. You will probably understand them better than me with your research background.”

I agreed that I would look at them.

But inside, I was upset, and perhaps even more upset because I knew there was no convincing Uncle Peter to get vaccinated. If he was concerned enough about

## Humble Medicine contd.

avoiding a SARS-CoV-2 infection that he was taking other remedies prophylactically, why not just get the recommended vaccine and be done? Was he worried about the newness, the safety of it? Well, he needed to look no further than his wife, mother, children, and niece. Except for the youngest kids, we had all been vaccinated, and we were fine.

Nonetheless, I had told Auntie that I would read up on ivermectin, so one of those warm summer days, I sat at the brown mahogany dining table, propped up by a pink pillow so old the cotton was coming out of its sides. I listened to a YouTube video she sent me; a scientist with many degrees walked through the most recent meta-analysis on the effectiveness of ivermectin on treating and preventing COVID-19. I was ... surprised? While the drug wasn't bulletproof, it was associated with antiviral activity amongst the ill. I would later do my own research and come across many trials and meta-analyses that echoed the same message. Maybe there was something to this? Embarrassment trickled in. As someone who was getting her MD and MPH, I felt that I should have been aware of any and all potentially effective strategies that were being used to fight this pandemic. How had I missed this information?

My 3-week vacation from school ended rather quickly. After visiting all the family and friends of my heart's desire, I returned back to the grind that is medical school. As it was impossible to avoid conversations about COVID-19 and vaccinations, I couldn't help but think of Uncle Peter. Alternative prophylaxis or not, why wouldn't he just take the vaccine? What was he – what were so many people – so concerned about? Well, little did I know that my question would be answered in a very unexpected way.

Summer's warmth had long gone, and the orange, yellow, and red leaves of fall were now covered by the pearly white snow of Cleveland's winter. My fingers stung whenever I walked outside, and my exhalations, cooled

by the frigid air, would collect water beads on the inside of my blue mask, moisturizing my nose in ways I didn't ask for. But none of this cold could take down the heat inside Zara's body.

The fibers of her muscles burned and popped. Once her coping strategy, movement and any form of exercise now served as a cruel reminder of her physical limitations. It ripped her muscles and sent her heart rate skyrocketing. Her ability to think became shrouded by fog. But the worst symptoms came at night. When she would try to lie down in her bed, a feeling of suffocation would overwhelm her. The compressing pressure of the darkness around her would steal her breath until her feet went numb, her chest hurt, and panic set in. Panic attacks. She had her first-ever attack one cold and snowy night in January.

She texted me after days of suffering to please pray for her. We FaceTimed and prayed together, asking God for healing and revelation. This became a nightly routine. We tried to figure out what was causing all the pain, brain fog, and anxiety. Perhaps she was working too hard. An overachiever, Zara put a lot on her plate and expected herself to excel at it all. But while the pressure could maybe explain the anxiety and panic attacks, it was harder to understand how it would cause such severe muscle pain. Maybe she was super sore. As she was a former ballerina, she spent hours dancing hard in the studio on her days off, and maybe she had gone too far. But soreness couldn't account for the psychiatric symptoms. Maybe it was a combination of factors? But why would they last for weeks on end?

"I think it could have been the booster," she confessed one night on FaceTime. My eyes widened as I stared into her face on my phone. Something about that idea struck a very scared chord inside me. I had heard about adverse events after vaccination, but those stories felt more like distant statistics until they took on the body and shape of my friend.

## Humble Medicine contd.

At the hospital she worked as a nurse, she was required to get her booster. She had bad reactions to the first two and was admittedly nervous to get this third, but to comply with the mandate and to protect herself, she went ahead and got it. She was fine for a week, but then things started heading downhill. She had been tested after her booster and many times after getting sick, but every SARS-CoV-2 test came back negative. She went from doctor to doctor, and we surfed the web, finding that she wasn't alone in her symptoms post-vaccination. An article in *Science* that came out about rare coronavirus vaccine-related adverse effects literally described her dysautonomia.<sup>1</sup>

On a very blizzardy winter day, I remember wrapping up a learning objective presentation on imaging lung cancer when I noticed the number of text messages on my little blue iMessage icon on my Mac increase in number. When I opened it, I fought back tears. It was from Zara, and she had texted me that she had been worked up and diagnosed with a chronic illness due to a COVID vaccination reaction.

Zara was chronically ill? Zara was chronically ill! I threw my hands up in anger and dismay. How could this be? Zara had been so healthy to the point that I envied her, and now she was going to have to battle symptoms of anxiety and brain fog and muscle pain and a racing heart indefinitely? All because she had tried to protect herself with her booster shot? This couldn't be! I shook my head as I remembered patients I had seen in longitudinal clinic, where I would wear a white coat that said "I know about health and disease." A number of them reported adverse events post-vaccination, but while I listened to them with a nod, in my heart I believed they were forming temporal associations between vaccination and something unrelated.

A solution-oriented person, I spoke with Zara and others about what needed to be done. A woman with a plan, Zara already knew what she was going to try to improve

her health, but on the administrative side, I believed we needed to conduct research on the various vaccines so that we could characterize those best suited for which vaccinations, meaning we needed to retrospectively collect data on adverse events, and then all schools and hospitals should be aware of these findings so they could more cautiously advise their students and workers, and then, and then, and then—

But there is a place to pause and consider as well. Thinking back to my summer days with Aunty and Uncle, perhaps I should not have been so upset with Uncle Peter. Perhaps I should have been doing more research on the different methods people were trying to treat COVID-19 instead of shrugging them off as snake oil. Perhaps I should have listened to patients in longitudinal clinic with more respect. I could not deny that the vaccine had done much good, especially in regards to keeping people with COVID-19 out of the hospitals. But even so, in the wake of the new information confronting me, I could not deny that moving forward in my career, I always needed to remember the importance of humble medicine, for some of life's most elusive realizations come with the dawn of humility.

### *Reference*

1. Couzin-Frankel J, Vogel G. In rare cases, coronavirus vaccines may cause Long Covid–like symptoms. *Science* [Internet] 2022 [cited 2022 Feb 14];375(6579). Available from: <https://www.science.org/content/article/rare-cases-coronavirus-vaccines-may-cause-long-covid-symptoms>



**Afternoon at Shaker Lakes**  
August Culbert | CCLCM Class of 2026

# Lamentations

Chineme Onwubueke, BS | CCLCM Class of 2025

My soul groans  
For the patient on the phone  
Suicidal thoughts attack her when she's all alone  
Doctor asks her, "Kerry, tell me, do you wanna die?"  
Silence. A bitter, sad cry

My soul aches  
For the elder – so much medicine he takes!  
Illness keeps on coming for him – no mercy, no breaks  
Another medical procedure tasked by Doc to him  
He starts to sob, releasing all the agony within

My soul moans  
For the patient whose age is one plus my own  
It's hard to get him to look at me instead of his phones  
Shots to the back almost took his life away  
Regardless of our care, back to that neighborhood he'll stay

My soul breaks  
In the face of medical mistakes  
We do our best – life and death are really high stakes  
But sadly, the truth is to err is human  
For this, my neighbors lost their dad, and Earth's lost more than a few men

My soul groans  
My soul aches  
My soul moans  
My soul breaks

It's like why are we here?  
Why should we care?  
Isn't it futility to fight entropy?  
What is our purpose here in reality?

But no  
It can't be  
There has to be a reason for our resiliency

Maybe we're building up to a greater calling  
Climbing back up to the heights from which we've fallen  
A place with no tears, no snares, no fears, no scares  
Loved by a greater One who truly cares

There's beauty in medicine that inspires me  
A crossroads of despair and hope – the beauty I see

Like that patient – raped and kidnapped by one who could slay her  
We bonded when she told me about her comfort in prayer

Or that mom – searching for answers for her dying daughter  
With a student, found the right doctor after so many had fought her

So yes my soul groans  
Yes my soul aches  
Yes my soul moans  
Yes my soul breaks

But when I see the love conveyed by healthcare workers  
in our broken world  
I can cope  
We have hope



# What Endures in a Life in Medicine

Kathleen Franco, MD

To endure can have many meanings such as to abide, stand, bear, suffer, and tolerate. Each of us have had many patients who bore their illnesses bravely and tolerated the suffering yet were grateful for their care. One might also think of enduring as lasting, such as when we describe mountains and oceans. Yet we know they change with rising water, wind, erosion, or other events of nature. Physicians also evolve over time in their positions or what they are asked to do in their professional lives. One enduring characteristic of most of them is the desire to help others. Caregivers can be distressed by a policy, a system, a nagging pandemic, and much more. Yet when considering all and reflecting on their work, they still care a great deal.

Once retirement comes, enduring materials, such as scientific articles, don't mean as much as they once did. What is important are the enduring relationships with family, trainees (my extended family), colleagues, and former patients that one cherishes. Over the past three weeks, I have moved from helping one family in Seattle to another in Chicago and yet a third this coming week in Cleveland. Enduring love for one's family is natural and is present especially when there are unexpected tragedies, disappointments, or losses that are not uncommon. It is natural to want to be there to support them. There are so many mentees I treasure from the earliest to the most recent. Whether it is a text, email, LinkedIn message, phone call, postcard, or holiday greeting, I am thrilled to hear from them! Thinking of those who now carry the torch long past my lifetime is a great joy to me and I consider it one of my greatest blessings.

Patient relationships are both enduring and endearing. My very first outpatient as an intern in longitudinal clinic was a developmentally disabled 13-year-old girl. She lived with her parents and two smart older siblings. Let's call her Shirley. Her parents were both schoolteachers and had searched for the best

resources they could for their youngest child who was disabled from birth. She had the best education and care available, but her IQ was only 60 and she could communicate only on a very limited basis. Shirley could print her name and do repetitive tasks in the workshop as she grew older. Through the years I helped both her parents, her older sister, and her grandmother in addition to Shirley. Practicing psychiatry is certainly different from practicing family medicine, but in this case, there were similarities. From 1975 to 2004, her parents brought her to see me, initially in Toledo and later in Cleveland. It was a three-hour drive each way toward the end, but they insisted. When they told Shirley that she was going to visit her doctor, she would get very excited and want to leave home immediately to make the trip. Once she arrived, her smile radiated across her entire face. She would squeal "my doctor" and give me a big hug. I can still hear her and feel those hugs. Then her father died, and her life changed dramatically.

Her mother had to move to North Dakota to be closer to the older daughter and could no longer bring Shirley to see me, but she continued to write letters and send cards with Shirley printing her name at the bottom. A few years later, her mother died, and she went to live in a group home nearer to her older sister. Shirley is 60 now and doesn't have the opportunity to send cards, but her caring for her old doctor in the past is both treasured and enduring.

## What Endures... contd.

Teddy was eight years old when he was diagnosed with retinoblastoma. In those years there was very little except pain relief that we could offer. Toward the end of his life, his mother brought him to the hospital for debridement and help with bandaging. Visiting nurses weren't available to him. The hospital residents, faculty, and nurses became their extended family. Teddy asked me and another team member to sit with him and said he had a question to ask us. He was afraid of what might happen to his mother after he "went to heaven."

He knew she was worried and asked us to raise money to help her. We did just that and made sure she understood how much Teddy wanted her to go on with her life. After he died, a group of us, including residents, faculty, and nurses, all went to his funeral. When we walked out into the sunshine at the end of the service, we sensed his enduring peace. He was proud and happy of what he had done for his mom, and he inspired the rest of us to do our best in helping others each and every day.



I was out birding one autumn day when I came across this chipmunk chilling in the breeze on a small tree branch. I observed it for several minutes and it was simply enjoying one of the last warm days of the year without a care in the world. I often look back at this photo to remind myself to stay present when things get too hectic.

### Contentment

Philip Wang | CCLCM Class of 2024

## What Is Anticipatory Grief?

Vidhi Patel, MD

It was Sunday night and my mom was helping me pack. I was preparing to leave India to start a new job at the Cleveland Clinic. She had that proud mom face throughout and we were happy that, after a COVID-induced wait, I was finally taking a step towards the goal we both shared. All my life, I was a pampered, homesick girl. I blame my mom for that. She always gave me more than I ever asked for. She struggled all her life to see me where she wanted me to be. This dream I live for her.

I first arrived in New Jersey where my aunt lived since I had a few days left for my job to start at the Cleveland Clinic. I was struggling to settle in, keeping myself busy with reading, some exercise, cooking, and spending time with my cousin. I knew my mom was alone but I kept telling myself that we both have to be very strong to achieve our dream. I was talking to her every day through video call and I noticed that she was coughing a lot for the last three to four days. I was scared that she might have caught COVID. I asked her to get a CT-scan of her lungs done as soon as I realized that it was only getting worse.

A day later, my life turned upside down. I knew she was going to die soon. This is the con of this profession. Her scan showed big tumor masses. My entire family was devastated. My mother was alone, the little time she had left to be spent with my abusive, alcoholic dad.

“Is career more important than family?,” I think to myself as I write this from my desk at the Cleveland Clinic. You can guess what I chose. No, my career is not more important to me than my mom. I am doing this for my mom. She blackmailed me, saying that she would not get palliative treatment if I didn't choose my career over her. Now I am scared to wake up every day. My mom blames me for her severe side effects with

chemotherapy and target therapy as I forced her to get treated. But I am doing okay. I will continue to show up as long as I can.

Anticipatory grief is very similar to grief. The grief you feel before your loved one dies, as you expect or anticipate the death. Features include preparing for life without the person, finalizing end-of-life plans, visualizing the impending death, and withdrawing from activities prior to the death. Knowing there is a term for what I feel helps me immensely.

To anyone who is going through a similar phase in life, I hope some of my suggestions give you the strength to continue showing up every day.

Please be honest about your feelings. Say what needs to be said. Take the time to settle legal, financial matters but also find time to examine unresolved issues. Find new ways to create memories with your loved one. While their body may not be as agile, you can find something to enjoy together like sitting in the backyard, cooking together, or playing simple games. Find a support group or friends who are experiencing something similar. Try putting your life on hold. Continue reaching out to friends and family, celebrating holidays and making memories.

## A body

Ava Fan | CCLCM Class of 2025

Winner (Poetry), CCLCM Medical Humanities Contest

Can you divide a body from a person —?

(I didn't used to think so.)

My mother would peel fruits for me in the summer heat,

A slender knife in hand, skimming the surface,

A clear separation.

Now I am here in this white coat, and

there is a body in front of me,

But not a person

(or so, I am told.)

“Practice —

Don't be afraid.”

We line the side of the bed in the ICU,

a soft sheet tucked tightly against the rigid contour of the frame.

We are told,

a reflex,

a gasp,

a grimace,

a pain,

Is the mark of a body, alive —

Humming along, a sign of continued life.

But is it a person?

Why are we using pain as an instrument,

If this is a person and not a body?

If this is a daughter, and not a memory,

If this is a mother,

And not a story?

It is not so easy to split a soul from a person,

Like one does the core from a fruit, or

A plant from the soil, uprooted.

We do it now,

and —

It is taught,

(But we choose to learn.)

We divide the body from the person, not cleanly,

But with a haze, a fog of choice.

## No Coincidences

Amy Rosenfeld, MD | Spiritual Care Family Liaison

When I retired from an Internal Medicine practice, I became a Family Liaison at the Cleveland Clinic Main Campus. We help with logistics after someone dies in the hospital. Sometimes hospital operators or nurses refer calls to us which don't fall under our remit; we always try to help.

Recently, a prison chaplain from the Ohio Women's Reformatory called our office to confirm a death. She'd been told that the grandmother of an inmate was dead and was calling to corroborate the information because sometimes people play the cruel hoax of falsely reporting that a prisoner's loved one has died. Our team only deals with in-house deaths, and this woman's name was not on our list. But the chaplain had called several offices and I hated to make her call yet another number, so I told her I'd make inquiries. I found the electronic medical record and learned that the woman was enrolled in Cleveland Clinic Hospice at home. There was no death note or discharge summary, so I called the hospice office to ask about the case. I explained the circumstances to the secretary - granddaughter in prison...prison chaplain...confirm death...

"What's the patient's name?" asked the secretary. When I said the name, she gasped. "Oh no! Mrs. \_\_\_\_? She died?" I was taken aback. Do administrative staff get to know patients? "I'm sorry," I said, "You knew her?" "Yes," she said. "Not from work. Many years ago, I was a nurse's aide at the county nursing home, it was called Sunny Acres. We worked together. She was like a mother to me."

Now, I was familiar with Sunny Acres; it had been the county TB sanatorium before becoming a skilled nursing home for the most frail, disabled and impoverished county residents. When I was a medical resident in the

1990s at County Hospital, we dreaded 2 am admissions arriving by Life Flight (helicopters ambulances) from what we ruefully called "the Acres of the Sun." The patients seemingly all had dementia, pneumonia and bedsores, no I.V. access and no D.N.R. orders. We would groan at the 2 or 4 or 10 volumes of medical charts stacked in the work room, and tried to decipher the handwritten notes of previous interns and residents, some of whom were our attendings now. To my shame, I didn't always see the full humanity of these patients on those sleepless nights. And I am sure I never thought twice about the nurse's aides who cared for these people night and day, for years.

Then the secretary told me "She was always talking about her granddaughter. She raised her. Oh, she loved her so much." The woman sighed - I imagined her shaking her head: "Prison?" A pause, and again she said, "She loved that child so, so much."

The secretary gave me the Hospice doctor's name. I called him to confirm the death and called the chaplain back. I told the chaplain how, totally coincidentally, the Hospice secretary had known the deceased grandmother and of course, I related what the secretary had said about the relationship. We marveled at the strange set of coincidences - the call to our office, the unwritten death note, the particular secretary who was on duty.

I don't know what it feels like to be sitting in a prison cell and be told that the woman who raised you is dead. Who knows how that relationship ended, what was said and what was unsaid. When the chaplain relays what the secretary told me, will the inmate feel relief or regret? Will she dismiss the coincidence, or will

## Coincidences... contd.

she wonder, as I do, whether this was some cosmic transmission of a final message from grandmother to grandchild: "I love you."

It feels like redemption. For the granddaughter, and for the chaplain, too, who can look at the inmates and remember they were children once, and beloved.



### **Bloom**

[August Culbert](#) | CCLCM Class of 2026

Phalaenopsis orchids bloom in the winter at the Cleveland Botanical Garden

# Endure

Rev. Amy Greene, D.Min. | Senior educator and Former Director, Center for Spiritual Care

To Endure:

“to suffer with patience” (Oxford English Dictionary)

To suffer with patients? Oh yeah, we got that.

Latin: indurare ‘harden’, from in – ‘in’ + durus hard

To endure is to suffer through, to last, to harden, to remain – standing?

How about, simply, to remain — prone, exhausted, softened by the poundings. Tenderized. But still here.

Jesus said the last shall be first. Shall they who last be first?

Isn't the same root of “endure” embedded (like a patient) in the medical term for what surrounds our brains and makes our spines stiffen? Dura mater. Seems like it's Latin for “tough mother?” You have to be one tough mother these days. These Covid Days.

Forget resilience for now — bow not to the false and relentless gods of “bouncing back.” Forget rising stronger for a minute. Welcome the gods of Sabbath.

Can't it be enough sometimes just to endure, to remain, to last? To stay put, when everyone else has left the building? Wee hours. Wee hope. We stay.

With apologies to Nietzsche, may that which doesn't kill us make us kinder, not stronger. Stronger is overrated. Give me steadfast and friendly, any day.

May that which doesn't kill us make us ready — after a spell, at last, to last — to just keep being there.

## Coming of Age

Amala J. Alenchery, MD

I encountered my first complex 11-month-old patient with one of the worst cases of graft-versus-host disease following a multi-visceral transplant in the first month of pediatric residency. His prognosis so grave, the then doe-eyed version of myself questioned why I chose this career. The next morning, I witnessed a glimmer of hope amidst the darkness: his innocence as I watched him happily eat banana purees, without a care in the world (while we struggled to fix his hyperkalemia). Over the months that followed, his condition worsened, and he ultimately succumbed to his disease. In the resident debriefing session that followed, I silently listened as my colleagues spoke of their feelings and expressed gratitude and honor for having cared for him. Then, I moved on to the next rotation to tend to more sick patients and this infant became remote memory.

Fast forward two years through a raging pandemic, I'm in the final year of my (first) training. COVID has turned lives upside down and there isn't a soul spared from some terrible loss. Every other disease process thrived through the pandemic – independent from the torment of the virus, the loneliness, and the isolation which came along. I have witnessed more death in the past year than in my entire lifetime. My beloved grandmother who lived a long, fruitful life was slowly dying. Torn between my love for her and my knowledge of the sciences, I desperately bargained for a few more months so she could bless me on my wedding day, but death pays heed to none. Over time, I finally accepted her loss and moved on.

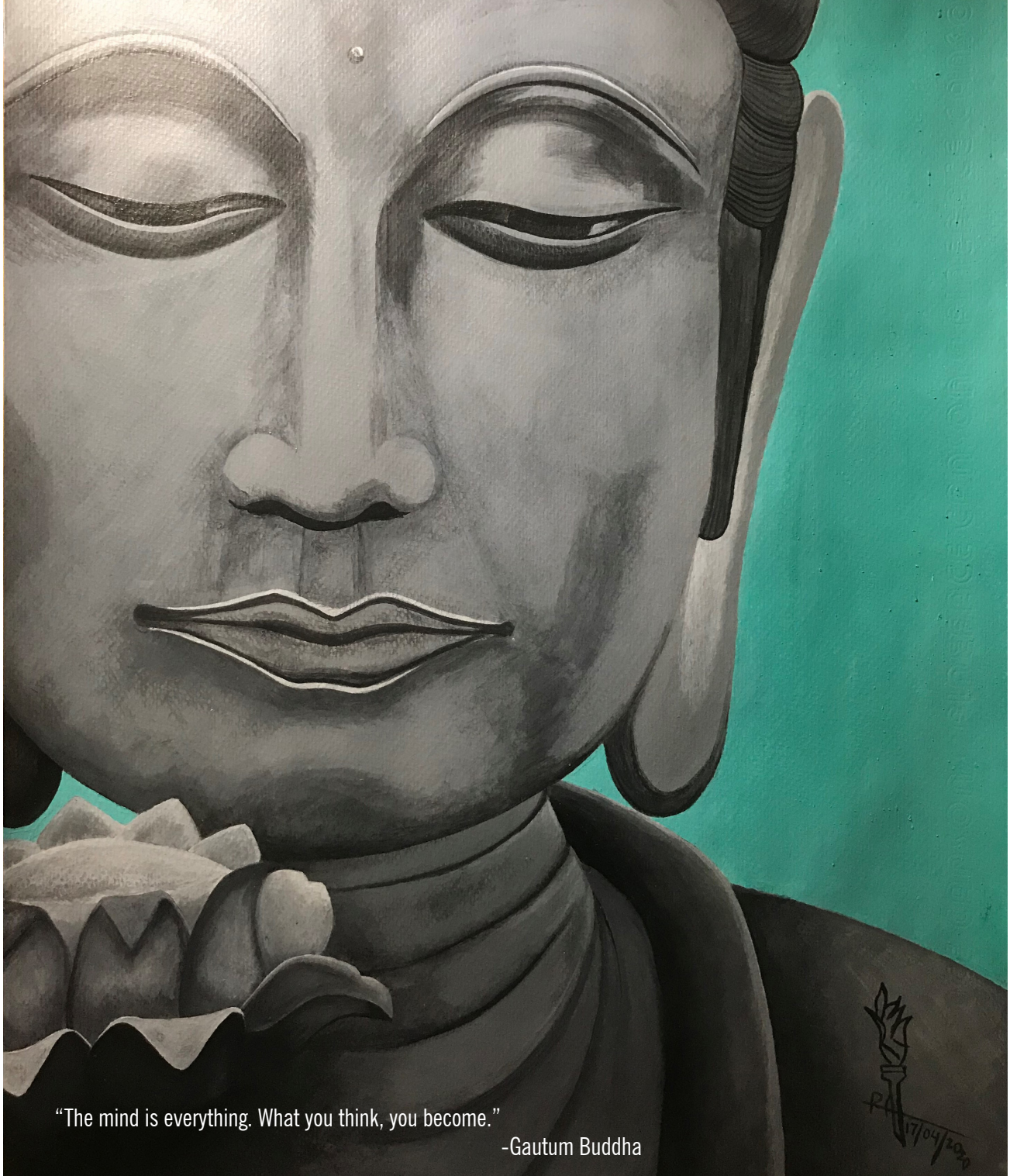
I then met a recently engaged young lady found to have metastatic disease unresponsive to therapy, bed-bound by her pain, nausea, and malnutrition. She had a fabulous in-hospital bridal shower with close family and the healthcare team. Less than two weeks later, in that very same hospital bed, she peacefully passed away in her mother's arms. A little girl and an adolescent boy with cancer so advanced that palliation was their only choice for a peaceful end. Therapies exhausted upon a happy young man to halt his disease until he bled

internally. Months passed with more mortality and then came the devastating loss of someone very dear to one of my friends.

Medical school education encompasses rare genetic disorders, traumas, malignancies, premature babies who cannot keep up with their bodily demands, and even critical care patients categorized as grave scenarios or diagnostic dilemmas to be solved. The burden of choice regarding cure, palliation or an acceptable life with disease are impossible decisions expected of physicians and even patient families. Knowing there is no therapy, no medication, no amount of wealth or resources with the ability to entirely halt the process of dying makes one bargain for a regimen with the most tolerable side effects or interventions with “the best possible outcome.”

Everybody says that pediatrics is an easy specialty because of how resilient children are and how they overcome ailments to grow into a person with aspirations and a whole life ahead of them! No one ever tells you how much more devastating each loss is. How you lose a piece of yourself every time a child tells you that they are afraid to die or worries for their family. Being faced with the reality of these sacrifices gives a whole new perspective about the purpose of medicine. I learned that this feeling of utter devastation does not last forever, that once the grief settles, what remains are the memories, the love, and the lessons each patient taught me. I will never forget the families who have endured extraordinary losses, their gratitude for the care provided in their lifetime, and for a dignified death. There is a quiet that follows the exhaustion of waging an internal battle against circumstances beyond one's control. I have been humbled by the peace brought about by acceptance. These experiences have taught me about persistence, endurance, and growth. They have taught me to forgive myself for being human, and for caring too much. They have taught me the truth that I cannot fix everyone, and to accept that sometimes even I need to be saved.





"The mind is everything. What you think, you become."

-Gautum Buddha

## Perseverance

Roma Raj, MD

It takes dedication and perseverance to achieve your goals, to face all the hurdles life throws your way and succeed.

# Reflections of a First-year Medical Student

Leila Bushweller | CCLCM Class of 2026

As a part of our APM curriculum, we reflected on the painting “8 ½ Medical Students.” In the painting, the students crowd the door, blindfolded. During much of my time in the clinic, I often feel blindfolded myself, acutely aware of my lack of knowledge and expertise. This feeling was especially magnified in my first session at LC, when I still had no idea what EPIC was and had never heard of a beta-blocker. In that first session, I followed my preceptor into the room, introducing myself as a first-year medical student. I was careful to include “first-year,” to ensure that the patient had no expectation of me being able to offer anything remotely useful to them. I also opted to leave my white coat in the workroom, too conscious of my own ignorance to be bold enough to don the symbol of medical knowledge. In that first session, I was hyper-aware of my own presence, feeling as though I had made the small examination room even tighter as I navigated the awkwardness of introducing myself, closing the door, and finding a corner to stand in, all within the first few seconds of meeting with the patient. In many ways the painting reminds me of these initial experiences, crowding the doorway with my medical ignorance.

Another component of the painting that stands out to me is the outstretched, palm-up hand of the patient. The IV in the patient’s arm is a symbol of medicine, and I see the upturned nature of their palm as them welcoming medicine and physicians into their lives. Given that the painting is from the patient’s perspective, they would “see” that the student doctors in front of them are all blindfolded. Yet, the patient lets them into the room with their outstretched arm and upwards palm. This feature of the painting reminds me of my first LC encounters where I entered the room alone to engage with patients. My medical knowledge, obviously, was still extremely low (though I did know what a Beta-blocker was by then). What struck me in these encounters was how

willingly patients allowed me to enter, ask them personal questions, and trusted me with their deepest concerns. I listened as patients told me about the passing of their significant other, their worries about death, and how challenging their anxiety disorder had become. In the moment, I focused on being present for the patient, much like I would do if I was listening to a close friend share their thoughts and fears. I realized from these early interactions that although I may still be blindfolded to most medical knowledge, so much of medicine rests in human interaction and communication. The “Get Well Grandpa” card on the patient’s table further underscores the privilege of caring for people, as everyone exists in a network of friendships, relationships, care and love. It is an incredibly unique privilege to be privy to individuals’ pains, worries, and fears, which I hope to never lose sight of during my medical career.

I am not sure when I will no longer feel like I am in the way, crowding the door. Medicine is a long journey, and there are many steps before I feel I may be able to enter a patient room alone and feel confident in my knowledge. Even after the years of training ahead of me, though, I still wonder whether the blindfold over my eyes will ever fully fall. The body is incredibly complex, and we are still a long way away from understanding and being able to effectively treat many diseases. However, what will remain constant is that I can endeavor to always remember the humanity of my patients and the vulnerability of the human condition. With this, I hope my patients will always welcome me, palm upturned.



## A Moment of Zen

Melissa Coronado, MD | CCLCM Class of 2022

A moment of zen on a snowy trail

## What Do I Have to Offer?

Nandan Kodur | CCLCM Class of 2026

“Hi, Ms. Williams, my name is Nandan and I’m a first-year medical student here at the Cleveland Clinic working with Dr. K,” I said to begin the interview, crossing one leg over the other in my seat. This was my third interview ever as a medical student, and I was excited yet anxious — excited to interact with another patient, but anxious about not possessing the medical knowledge to address her health concerns. “The reason why I’m here is to collect information from you that I will then present to Dr. K, after which we will both come into the room and have a conversation with you. How does that sound?” So far, so good, I thought to myself, reflecting on the delivery of my introduction.

“That sounds fine,” replied Ms. Williams.

“Great! Before we begin, I want to make sure that I’m addressing you correctly: Is Ms. Williams fine, or would you prefer I address you another way?”

“You can call me Sharon.”

“Okay, sounds good. So, Sharon, what brings you into the clinic today?” I asked, feeling a bit awkward addressing a woman who was over twenty years older than me by her first name.

“Well, I have pain on the right side of my stomach,” she said anxiously, “and it spreads to both sides of my lower back.”

As Sharon spoke about her stomach and back pain with apparent distress, I had an urge to immediately inquire more about this pain, but I resisted the urge and stuck to my interview script, which required me to first ask if she had any other medical concerns. “I want to learn more about your stomach and back pain so we can better help you,” I said, “but first I want to hear about any other medical concerns you may have so that we can address

those as well. So how else can we help you today?” Dang, I thought to myself — I rushed that transition. While sharing information about her stomach and back pain, Sharon was visibly anxious. Recognizing this, I should have slowed the tempo of the interview and acknowledged her worries rather than breezing to the next question. Yet my mind was too preoccupied with chugging along and completing the interview in a timely manner, especially since my last patient interview had gone over by twenty minutes. Alas, there’s nothing I can do now — I just have to move on and do better in the remainder of the interview.

Sharon went on to mention other medical concerns such as foul-smelling urine and a burning sensation in both of her thighs and buttocks, symptoms that she thought might be linked to the pain in her stomach and lower back.

After eliciting Sharon’s primary concerns, I transitioned to gathering more detailed information about these concerns, a phase of the interview known as the history of present illness (HPI). I probed Sharon about her symptoms — using the mnemonic ‘SOCRATES,’ which I use to recall the key pieces of information that should be obtained in the HPI — scrambling to jot down barely legible notes in my notebook. And contrary to earlier in the interview, when I had failed to sense and acknowledge her distress, this time I set aside my agenda and paused for a moment to acknowledge and validate her concerns. When Sharon began describing the physical and emotional toll her pain was taking on her and how it was disrupting all facets of her life — from her ability to sit in a chair all day and perform her job as an insurance agent to her ability to get quality sleep — I set down my notebook, looked into her eyes, and just listened.

## What Do I Have to Offer? contd.

“And the worst part of it all,” she said, “is that I’ve been to the doctor’s office seven times over the past few years for this pain, and still nobody believes me or does anything to fix it.”

“I’m sorry about that, Sharon,” I responded. “I know you feel like you’re not being heard, and that must be frustrating for you.”

“It really is,” she replied in a despondent tone.

As Sharon continued to unload her feelings, I noticed that my sense of urgency to complete the interview on time dissipated — so what if it runs a few minutes over, I thought to myself.

Once she had finished voicing her concerns and frustrations, I completed the HPI and proceeded to my final task, which was to listen to her heart sounds. As I finished auscultating Sharon’s heart sounds and lifted the diaphragm of my stethoscope off her chest, she said, “You know something, you’re going to make an excellent doctor one day — I can just sense it, I just get the vibe.” Sharon went on to thank me for believing her and taking her concerns seriously. “Thank you for listening and caring.”

When my conversation with Sharon began, I was anxious. This was one of my very first patient interviews, and I was dubious as to how I might be able to help. Indeed, I questioned whether I — at this stage of my training, lacking medical knowledge and experience — was worthy of interviewing Sharon. As the interview progressed and I became engrossed in Sharon’s story, though, my anxiety melted away. Though I could not resolve Sharon’s health issues, I could still offer something valuable: a sympathetic ear. And by making Sharon felt heard, I was able to validate her concerns and offer her something she craved.



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## Respite

Miranda Arakelian | CCLCM Class of 2026

## What We Learn - Maggie May

James B. Young MD

Executive Director of Academic Affairs, Cleveland Clinic

Physicians, and more generally, healthcare providers, enjoy privileged adventures. Focusing on disease prevention, diagnosis, treatment, and sensitive details of a patient's world with their most intimate thoughts influences us as compassionate beings. William Osler said, "to prevent disease, to relieve suffering, and to heal the sick – this is our work." We are indebted to patients for teaching us much about life to accomplish this mantra. After all, therapeutic partnerships are a bidirectional enterprise. Stories of those relationships are important and need sharing for us to grow, mature, and gain insight while helping others. Decades ago, a patient that I met shortly after joining the faculty of Baylor College of Medicine became a watershed for me – one of thousands during my career. Her name was Margaret, but we called her Maggie May because she loved the iconic Rod Stewart tune of that name. It was a catchy but rather bawdy song. She was from Baytown, Texas, a gritty industrial Gulf Coast town, and was referred to a clinical research program focused on metastatic breast cancer. She suffered greatly. Her family loved her dearly and, by the end, so did we. A 1981 New England Journal of Medicine publication (November 12th, 1981, volume 305 pages 1195-1200) immortalized her and others in the program with an illustration of tumor cells which had caused a grotesque metastatic infiltration over her mastectomy site. We were attempting a radical therapeutic approach to a case we thought was hopeless. Though it was over 40 years ago, the experience profoundly influenced and still haunts me.

Maggie May (the "May" moniker also because her experimental treatments began in the Springtime) was our first patient to undergo plasma perfusion over Staphylococcus cell wall Protein A, which had been immobilized on a charcoal filter with an ether based solution, and then reinfused using a plasma apheresis system. I thought we had figured out how to attenuate toxicity during our animal experiments, but we hadn't. With Maggie May, we watched amazed as the ugly metastatic mass on her chest wall (that had also spread to her bones, lungs and liver) heated up, flamed red, blistered, and became painful in minutes during treatments. It was dramatic. We were hopeful this was a sign of tumor necrosis, and it was. During the infusion, she would comment "I can taste it!" It excited her. She had hope. But she would also develop fever, rigors, wheezing, tachycardia, and hypotension. Uncertain what might be happening within hidden metastatic sites, she bravely endured and I was terrified. She could, indeed, "taste it" – and I smelled a distinctive scent of ether as she exhaled. Ether eluted off the charcoal accounted for the odiferous breath. Despite her suffering, she insisted we continue a protocol of weekly treatments because the tumor was literally melting away, and we always managed to pull her back from the brink. Epinephrine and dopamine became our best friends. We had few other options.

But the story is actually about something she said to me during one especially egregious treatment. It emphasized for me the importance of listening to our

patients; not listening during a chief complaint or detailed review of symptoms, but LISTENING to the patient. During one of her treatments that caused an awful and frightening bed rattling rigor I said to her, “Maggie May, you are my patient, but more, my hero. You are so brave.” Yes, our patients are heroes and heroines. She responded with difficulty, “Dr. Young, do you know what it means to be a hero?” I was embarrassed that, actually, I did not. And then she said, “A hero is someone who never lets anyone know just how frightened they are.” It is true. When wearing the White Coat and stethoscope badge, and perhaps all day, every day, we mustn’t forget that.

Maggie May also loved history and was well read. During many long hours camped at her bedside, we talked about all things historic. One of her heroes was Winston Churchill. She told a likely fallacious tale about him one day. She related that she had read of Churchill being invited to give an Oxford (or perhaps it was Cambridge, or perhaps not) graduation (or other) address. She described her understanding of how in his feisty, imperious and iconoclastic way, Churchill refused to wear graduation regalia, sat up on the event’s dais, wore his bowler hat, smoked his cigar, and when introduced, stood up brusquely, marched to the podium, took off his bowler, placed his cigar on a perch, grasped the lectern with both hands and stared intently at the audience for a very long time. She said that some thought, because of his age and medical history, he’d had a stroke. But after a few minutes, Maggie May noted, Churchill screamed – “Never give up, never, never ever give up!” And then turned away after grasping his cigar and hat before briskly marching off the stage. I realized that declaration had become a mantra of Maggie May. Indeed, her feistiness was Churchillian.

But the actual Churchill quote is more nuanced. In an address to Harrow School, an early age Alma Mater of his, on October 29th, 1941, not long after the Battle of Britain and The London Blitz, his closing remarks included the now often quoted rant: “Never give in. Never give in. Never, never, never, never – in nothing, great or small, large or petty – never give in . . . except to convictions of honor and good sense.” And so, Maggie May fought on, never giving in – until honor, good sense, and reality set in. Yes, we must learn that sometimes giving in is the honorable thing to do. I wept with our tight knit team that included special friends and colleagues, as well as her family, at the funeral.

Throughout our professional careers, patients like Maggie May will become our heroes. We must learn from them. We must share with them. Perhaps not too much, but just enough for them, and for us, to bond a bit. We must not forget the fine art of never giving in - unless faced with the honor, good sense, and reality of making difficult decisions, particularly towards the end of life. Remember our patients’ stories because they are our stories as well, and serve to guide us in our own lives and professional practices.





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