2023

Cleveland Clinic Lerner College of Medicine
of Case Western Reserve University

Third year can be tiring.
I get some rest when I can.

"Rest"
Ava Fan | CCLCM Class of 2025

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Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

Front Cover Artwork

"Serenity" | Maleeha Ahmad, CCLCM Class of 2024 | Lake Como, Italy

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DEAN'S INTRODUCTION

Stethos 2023 – The Intersection of Professionalism and the Humanities

The *Stethos* editors sent me an email today. A gentle reminder that they need the Dean's introduction to move forward with publication. I realize I overlooked their email a few weeks back and reflect on this professionalism lapse. Bad role-modeling for sure. With my apology comes a commitment to prioritize my time to complete my assignment to meet their deadline. I am reminded of our session in the Art and Practice of Medicine on "apology!" I devote the better part of the morning to reviewing *Stethos* 2023. This proves to be a wonderful gift as I immerse myself in the humanities viewed through the eyes of our students, residents, faculty and other health care providers. This journey starts with a beautiful photo of Lake Como, a sailboat drifting on the calm water. It sets the stage to quiet my distractions and lets me experience the powerful images and stories without interruption.

I take note of words and themes that emerge as I read.

As I create this word cloud, I am reminded again of the intersection of professionalism and the humanities. These words capture the essence of medicine. The images, reflections and messages on the pages of Stethos are poignant reminders of the privilege, challenges and opportunities in caring for patients and ourselves. So many of the stories reflect the aspirational values of professionalism in medicine. Stories, art, photography and poetry all enhance our ability to be present in our professional roles and enhance our ability to care for our patients, colleagues and ourselves.

Many thanks to our outstanding co-chief editors, Maeve Pascoe and Chichi Onwubueke, as well as the editorial board for their leadership, time and energy in bringing *Stethos* 2023 to publication. And thanks to all of the talented members of our community for enriching us with your contributions. *Stethos* continues to be a wonderful gift from our students and I am grateful. I encourage you to read, reflect and enjoy!

Bud Isaacson
Executive Dean
CCLCM
July, 2023

EDITORS' INTRODUCTION

Dear Reader,

As we prepare this thirteenth issue of *Stethos*, we find ourselves in an era where things seem to be settling down. After a difficult few years with the pandemic and other troubles, life seems to have returned to some semblance of normalcy. And yet one does not have to look far to hear of wars, political controversies, and other trials that continue to shake mankind, reminding us all of the need to find rest in order to face the challenges of a new day.

This year, several pieces reflect on our theme of recovery as we learn to live in what some would call the post-pandemic age. And yet recovery itself is not always easy, not always linear, and not always without new challenges. Within these pages, you will find contributions from students, residents, fellows, attendings, researchers, and other healthcare professionals that reflect on the human experience as it relates to recovery and beyond. Some of these pieces may sadden you, inspire you, challenge you, entertain you – all emotions that can be experienced in the journey of recovery and in life as a whole. We invite you to reflect on the emotions and sentiments stirred up in you as you digest this issue with us.

Finally, we are so grateful to you readers and contributors. *Stethos* would not be possible without your continued support. We hope you enjoy our latest issue!

All the best,

The Editors

Please note that all work presented in Stethos adheres to a confidentiality policy based on the Health Insurance Portability and Accountability Act of 1996. Authors and artists must protect the confidentiality of all individuals, whose personal details may not be revealed without their consent. Additionally, the students named in the caption for the image "Lessons in Anatomy" granted permission to be identified.

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all my relations

Olivia Dhaliwal

dear future healer
how can you heal others who are broken
if you have not experienced brokenness
yourself

how can you receive hurt people
if you have not experienced pain
yourself

how can you guide the hopelessly sick
if you have never felt hopeless
yourself

dear future healer
your days of brokenness
and pain
and hopelessness
will greet you someday
i hope you will have a healer
who has been there,
too.

We lived through times that shook us all

Matthew Goldman, MD

We lived through times that shook us all
A pandemic sweeping through our land
Now we're in a different phase
Where healing comes from every hand.
We're finding ways to cope and heal
To grow beyond fear and pain
As we slowly start to re-emerge
A new world takes its reign.
We worked from home and stayed apart
To take precautions for our health
Through it all, we also learned
The value of community and wealth.
We have seen the world come together
To help each other in need
Though the road was long and tough
We found a way to plant new seeds.
We are now in a new era
That calls for reflection and growth
An opportunity to heal old wounds
And find new ways to help and host.
So let us take this time to rest
To recover and to be renewed
Let our hearts and souls be blessed
With hope, love, and gratitude.

That Challenge Called Life

Richard Prayson, MD, MEd

Each day comes with challenges. But not all challenges are of equal weight. There are the small things that we have to deal with every day that in the grand scheme of life are not that important, not that meaningful, not that critical and yet, we find ourselves sometimes acting as if they are. The food we ordered at the restaurant did not turn out the way we expected. The weather is not cooperating with our plans. Some nice article of clothing is priced too high. Someone in a hurry cuts us off as we drive and we get angry and start swearing. It is easy to get caught up in our wants and needs and feelings of entitlement that we can lose perspective on what the true challenges in life are. There are many who have no food to eat, no roof over their head, barely enough clothes to cover themselves with. Those who are dealing with illness or addiction. Those who have lost loved ones or who are alone. There are those who are confronted with more difficult and often persistent challenges.

Recently, my wife and I were heading back home from a walk one summer evening. As I was nearing where I lived, this small dog suddenly appeared, slowly hobbling down someone's drive toward me. The dog had no collar and was not on a leash; he appeared to be lost, a stray. Other than some light brown fur around his face, most of his body had little hair on it. He looked mangy. He appeared very thin as if he had not eaten in a while. He had a very odd gait and appeared to have a hard time walking, as if he had been hurt or was in pain. He awkwardly made his way toward me with a hoarse sounding bark or grunting noise, the whole while wagging his tiny stump of a tail. Not knowing if he had escaped from a house nearby, I tried making my way up a walkway to the front door of the nearby home to inquire. There was one small step from the driveway to the walkway and the little guy struggled and tried multiple times before he was able to make it up that one step, seemingly happy and excited the entire time as he tried. Worried that he might be a stray, my wife was trying to find a number for a nearby animal shelter to call. Right before we called, the little guy's owner called out, looking for him. Somehow, he had managed to escape. We found out he had a neurologic problem, which is why he couldn't walk or bark very well and we did not ask about his hair loss. As the dog and his owner were leaving, I called out and asked what his name was. "Sparkle," was the response.

In thinking back on my encounter with Sparkle, there are a few things I thought about regarding challenges that come our way in life. The first was persistence. Sparkle was challenged and yet despite that, he tried and seemed optimistic and happy while doing so. He kept trying to walk and climb that small step even though it was a challenge and he must have failed a half a dozen times before he was finally able to climb that one tiny step. He kept trying to bark but could only make a raspy grunting sound. He did not shy away. He was not embarrassed by who he was, although perhaps, as a dog, he was not capable of being embarrassed. He reminded me that whatever our real struggles in life are, the big ones, we need to persist and try and we need to strive to be positive in doing so.

We also need to challenge ourselves to help those who are challenged. We are often quick to judge others, especially those who are different than us and those who may be less fortunate than us. We tend to rationalize their misfortunes as deserved. If they were not lazy and found a job, they wouldn't be homeless or without food and clothing. If they would just get help, they would not be addicted to alcohol or narcotics. If they just made an effort, they wouldn't be so lonely. Things are often not that simple. We often don't know the reasons why people carry the burdens with them that they do. Nor should we judge or assume what the reasons might be. Life's challenges are easier to accept and deal with if we try to confront them and we help each other out in confronting them.

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Tchaikovsky

Rene Aleman, MD

Music expresses that which cannot be put into words, it heals the wounds that medicine cannot touch.

Learning to Listen

August Culbert, CCLCM Class of 2026

In my first year of medical school, I was thoroughly overwhelmed. Balancing learning anatomy, human physiology, and the basics of the physical exam, I often felt I had little time for patient responsibilities. However, the times I did connect with patients in outpatient clinic, my fatigue seemed to evaporate—I left my world and entered theirs, temporarily taking shelter in their stories. I came to look forward to those rare moments where I could stop the firehose of medical education and just listen to my patients.

One Thursday morning, I shadowed a surgeon during outpatient clinic. Six patients were scheduled. The patients hailed from across the country—some had driven six hours to see him. For each patient, the importance of these meetings could not be understated: They clung onto every word.

One family came from South Carolina. A mother and a father came with their child, an energetic 5-year-old boy who suffered from Moebius syndrome. Unable to smile or make any facial expressions, he was visibly self-conscious—even at 5 years old—and frequently hid his face in his hands or in his mother's lap.

"Go on Jason, it's okay! You can show the doctor," prodded his mother.

Turning around, the boy looked at us and waited. I watched as Dr. Johnson discussed the options with the parents. Both were extremely familiar with their son's condition and were interested in a possible surgery to re-animate his facial muscles. It was possible to take small muscles from elsewhere in his body and re-implant them in his cheeks, allowing him control over his smile and parts of his lips.

On the father's lap, I noticed a list of questions to remind himself of:

"How often has he done this?"

"Any concerns about his ability?"

"Would you trust him with your child?"

As the visit came to a close, the boy and Dr. Johnson embraced. The boy clearly liked him. His parents seemed pleased. I was struck by Dr. Johnson's ability to befriend the boy and explain the risks and benefits of treatment to his parents. Did he know he was being evaluated so fiercely? Did he know how cautious these parents were to entrust their child in his care? How could he understand the magnitude of their pain when they found out their child had this condition?

The next patient was Mrs. Jefferson. I walked into the room first.

"Hello Mrs. Jefferson, I'm the medical student working with Dr. Johnson today!"

As we spoke, I learned her story. She had been in a car accident: A semi-truck had crashed into her car and sent it flying. She made three full flips before her 2011 Honda settled on the interstate. Miraculously, she survived and left without a broken bone.

But, she continued, she had significant neck pain and psychological stress since the incident. She felt unsafe driving near roads and felt like she had aged five years in the past few months. I sat with Mrs. Jefferson as she relayed her traumatic experience, allowing her to process for the 100th time what had happened. I knew that I could offer little by way of medical treatment, but I could listen. Five months of medical education had taught me that much.

With Dr. Johnson in the room, the conversation continued about her specific goals of treatment: What could we help her with?

"Well," she continued, "it's really my face, it's just … so different after the accident, I don't know what happened."

As Dr. Johnson probed further, it seemed like Mrs. Jefferson's issue wasn't nerve pain after all, or really any physical pain. She obsessed over her face, noticed every new wrinkle, crevice, and deviation. She was, in a word, having difficulty accepting her aging body.

As we realized this in the office, the visit shifted tone completely. It was clear that this patient was not a candidate for Dr. Johnson's services. He knew from that

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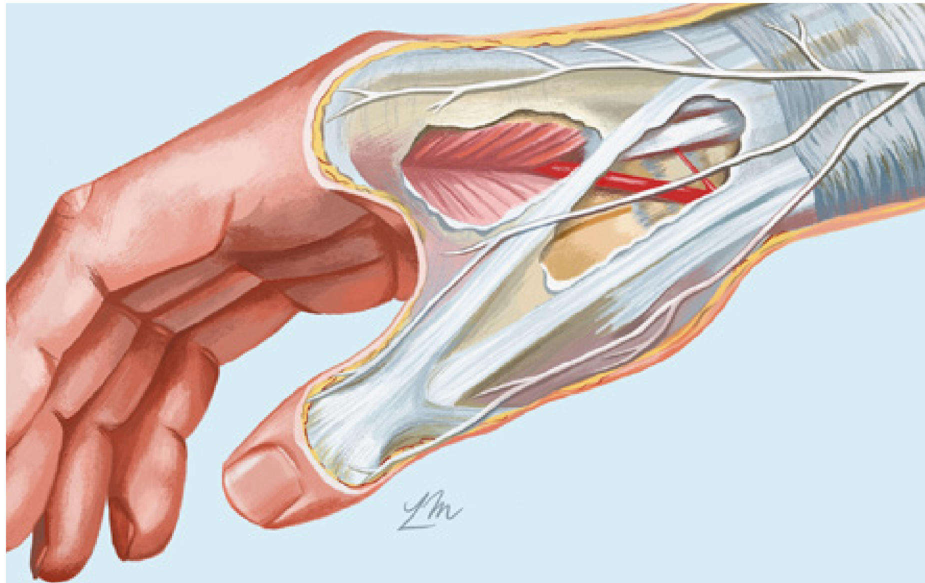
moment onwards he would never operate on this patient, would likely never see her again in his clinic.

But, rather than dismiss her concerns, Dr. Johnson stayed in Mrs. Jefferson's room for the remainder of the one-hour appointment. He listened patiently as she explained her other (likely psychosomatic) symptoms.

He respectfully referred her to colleagues in another department who might be able to help with her aging skin and wrinkles. Above all, he made Mrs. Jefferson feel heard. As we left the room and finished morning clinic, I reflected a moment on what I had just witnessed. Here were two patients, at opposite ends of the life spectrum, both seeking refuge from their outward appearance. Both entrusting their physician to deliver them out of their current state of suffering. One had the promise of youth: an exciting, revolutionary surgery to re-create a young boy's smile. The other was the reality of life: inoperable and unchangeable; the immutable fact of aging on the human body. And yet, for both of these patients, Dr. Johnson had met a critical need: He had been their doctor.

I knew, then, that I had learned an important lesson that day in clinic: No matter the diagnosis, no matter the treatment, the physician can always play an important role in the healing process. And the first step was to listen.



The Anatomic Snuffbox

Lianne Mulvihill

The anatomical snuffbox is a triangular depression found on the lateral aspect of the back of the hand. Its borders are the extensor pollicis longus (medial), extensor pollicis brevis and abductor pollicis longus (lateral), styloid process of the radius (proximal), scaphoid and trapezium bones (floor), and the skin (roof).

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Judge Not

Chineme Onwubueke, CCLCM Class of 2025

May 15th - ED-to-hospital admission: pancreatitis
Aug 18th - ED-to-hospital admission: pancreatitis
Sept 6th - ED-to-hospital admission: pancreatitis

I sighed as I reread the same diagnosis over and over in the patient's electronic medical record. This time, her medical story had changed slightly—ED-to-hospital admission: gastritis—but it was all from the same cause: excessive drinking. How many admissions did she need for the same thing before she got the message?

Well that was judgmental! my inner voice went.

I sighed again. Judgmental indeed, and as someone who had received so much education on the power of addiction, I knew I should know better. But to me, her hospital chart still begged the question, and frustration welled up in me as I realized all this increased her risk of developing pancreatic cancer.

After I finished reviewing her chart, I picked up the note template prepared for medical students and went on my way to visit our psychiatry team's new consult, Ms. K.

I entered the dimly lit room to find an elderly woman on the white hospital bed. Her graying hair was neatly braided back in two, her high cheekbones supported her deep brown eyes, and her dark skin glowed in ways I hoped my melanin would one day. It struck me how outer beauty can mask the illness within.

This was my final week on psych consults, so I knew what to do by now. We had been consulted for alcohol use disorder, so I asked her the typical questions to better understand her clinical picture and story: When was your last drink? How much do you usually drink? Are you seeing anything unusual? Hearing anything unusual?

"How was your childhood?" I asked as I continued the exam, scratching down answers on my note template.

"Well, that's why I started drinking at 13," Ms. K said, eyebrows raised as she shook her head. She then proceeded to tell me a story.

"When I was little, it was my momma, brother, and others. When my momma would go to work, my brother would jump me. He would molest me." She pursed her lips. "And he wouldn't let me eat or take care of me unless I had sex with him. So I started drinking at 13 to cope with it all. I ended up having a son with him; he's 40 now."

I gasped.

"I did manage to get sober a few years ago. But when my brother got sick, guess who took care of him? Me. And people would look at me and ask, 'How can you do that?' But I did it." She sighed, shaking her head again. "But when he died, on top of everything else that was going on at that time, I lost it. I started drinking again."

I was at a loss as I stood there in my white coat. The life of her brother led her into an addiction; the death of her brother led her to relapse.

"I am so sorry to hear this," I lamented, clutching my notebook. "Thank you … thank you for being so honest with me."

"Well, I always tell people, if you wanna get better, then you have to be honest about what you've gone through."

I agreed and affirmed her perspective before continuing with the exam.

"Ms. K, are you having any thoughts of suicide?"

"Well, not really. You see, my dad jumped into a lake and killed himself when I was little, so sometimes, when I'm upset, I'll say something in passing like 'well I'll just go and jump into the lake,' but I never actually would."

This was too much.

"Ms. K, I am so sorry."

That night, as I sat in my black office chair at my polished, wooden desk working on my journal club presentation for the next day, I just didn't want to do it. Who cared? My head fell into my arms on the desk as grief and nausea weighed me down. How could Ms. K have endured so much? To be so wronged by an older brother who was supposed to protect her. And to think I had judged her! What kind of a world was this?

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The next week, I started off my neurology rotation on the stroke service. There was a 30-year-old patient who was using PCP and cocaine. While intoxicated, she fell out of a car, hit her face, broke some facial bones, and had a disabling stroke in the process.

Oh, the temptation was so strong to think, "Sis, you did this to yourself." In medicine, when we repeatedly see so many traumatizing and upsetting things, I think we try to protect our minds by finding ways to put blame on "silly" decisions made by patients so that the world seems more just. *If I don't make silly decision A, then I can avoid bad outcome B*. And while it is true that our decisions do have consequences and that we ought to take responsibility for what is in our control, life is not so linear. The complexity of our existence extends far beyond our decisions, and our reality is influenced by things that we cannot always see. Hence why there is a need for mercy. We all need mercy.

As I contemplated the fate of this new patient, I remembered Ms. K and all she had been through that led her to a place of addiction. I thought of her determination to get well, and how she had gone directly from the hospital to an inpatient rehab center, not even giving herself a chance to go home for her birthday, lest she start drinking again. I remembered other loved ones who had suffered through unthinkable abuse that led them to cope using methods that were less than ideal. Full of these memories, I looked back into the chart of this young woman and decided to judge not, whispering under my breath, *"What's your story?"*

On seeing a patient during the protests

Baila Elkin, MD

Closing the exam-room door
I turned upon my heel and spun
I'd asked you all the questions for
your pap smear and there was no more
Our interview was done

When I presented you (with ease
words tripping blithely off my tongue
Like Gaelic to the Hebrides
Philosophy to Socrates)
I must have seemed so young

My preceptor looked up "we should
check in, her world's in disarray.
The streets are burning," as she stood
I shrugged and said I guessed we could
hear what you had to say

"How are you?" (I had asked the same!)
You told her "fine," your tone was light
She paused, again the question came
this time preceded by your name
Acknowledging there might
be more. There was. That much grew plain
You spoke, and it was like a prayer
of grief, of fear, of inner strain
The complex patterns of your pain
lay woven in the air

The air that grew so very still
How to respond? A sacred trust
We couldn't take away your ill
had no procedure, patch, or pill
to make the world more just

And so I sat there, reeling
as my preceptor took in your gaze
Your eyes and hers—such feeling!
that I thought: This too is healing
with the care that it conveys

We followed down path you led
though knowing not what you'd require
We echoed back the words you said
and as you left I saw your head
was raised a little higher

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Empathy in the third year of medical school

Philip Wang, CCLCM Class of 2024

I sat attentively on a warm afternoon as I listened to one of my first APM sessions of medical school which happened to be on empathy.

"Interestingly, the authors found that empathy scores drop during the third year of medical school, and they…"

Pfft absolutely could not be me! Empathy oozes out of me like water from the Mississippi delta, someone says they are sad and I get tears in my eyes. I have tears just thinking about it.

The pediatric ICU was my first rotation of third year. While the first week was a big adjustment, by the second week I was feeling like a real big boy medical student. However, I never physically saw most of the patients we rounded on. Instead, I followed along in the hallway with the sign-out sheet, which was borderline incomprehensible as it appeared to be written in abbreviation-ese instead of English. Patients became an unmarked door and a long list of medications, labs and imaging.

One day however, a patient was transferred in for a second opinion on brain death after drowning. We rolled the workstation in front of the patient room getting ready to round. Here however, we did not find an unmarked door. Taped pictures of the kid at his football games, birthday parties, and elementary graduations covered the door. I felt a strong emotional reaction, imagining the life that was taken away from this kid and his family. Yet almost immediately afterwards, I started wondering why I didn't feel this way about any of the other extremely sick patients on the unit we rounded on. Did the pictures really make that much of a difference?

"Alright medical student, could you tell us who this patient is?"

The surgeon peered across the table at me.

Oh jeez, did her name start with S? Shannon? Sarah? Susan? How the hell could I have forgotten? Do I guess at the risk of making myself look like a fool? Or just say I don't know? Damn it, what a terrible way to start the day.

"To be honest sir, I looked it up last night but I completely forgot her name."

The surgeon gave a brief chortle.

"I don't give a rat's ass what her name is, do you know anything about her medical history and what we're doing today?"

"This is a 64-year-old female with a past medical history of Type II diabetes and hypertension and we're doing an abdominal wall reconstruction after two prior ventral hernia repairs failed."

The surgeon briefly nodded and turned his attention back to the operation.

While I was grateful for the brief reprieve from the questioning, I was furious at myself. How could I have forgotten something so fundamental to a patient's identity as their name but remembered all her medical history without any difficulty?

---

pzzt pzzt pzzt

The phone in the OR rang, signifying that the frozen sections of the lymph nodes we sent down to pathology had come back.

"Lymph nodes positive for thyroid carcinoma"

Christ, I am going to be in here for at least another hour or two while they go digging around for more lymph nodes. I wonder when I will finally get home?

I froze.

Wait. What? What happened to you, Phil?? We just found out something terrible about this patient and all you can selfishly think about is when you will go home? What kind of future doctor — no, human being — are you?

To be honest, this one quick thought really affected me for almost half a year. I never really told anyone about it because I was too embarrassed to. One day, though, I was rereading *When Breath Becomes Air* by Paul Kalanithi on a road trip and came across the following passage:

"A few weeks in, [Mari] was assigned to assist in a Whipple, a complex operation that involves rearranging most abdominal organs in an attempt to resect pancreatic cancer, an operation in which a medical student typically stands still—or, at best, retracts—for up to nine hours straight…

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Fifteen minutes after the operation started, I saw Mari in the hallway, crying. The surgeon always begins a Whipple by inserting a small camera through a tiny incision to look for metastases, as widespread cancer renders the operation useless and causes its cancellation. Standing there, waiting in the OR with a nine-hour surgery stretching out before her, Mari had a whisper of a thought: *I'm so tired—please God, let there be mets.* There were. The patient was sewn back up, the procedure called off. First came relief, then a gnawing, deepening shame. Mari burst out of the OR, where, needing a confessor, she saw me, and I became one.”

A few months after my surgery rotation, I went back and found the paper** which demonstrated that empathy dropped during third year. The authors hypothesized several reasons for this, which included poor role models, overly demanding patients, and time pressure. However, after going through it myself, I can't help but to feel like the reductionist nature of clinical medicine is what caused my personal erosion of empathy. Patients went from individuals shaped by the diverse tapestry of life experiences that render each of us so beautifully unique to a long list of abbreviations of comorbidities, a trend of aminotransferase levels, bones and soft tissues rendered in black and white on a fluorescent screen, a marked surgical field surrounded by blue drapes, and a checklist of things we need to get done each day. Perhaps that is why I want to go into psychiatry.

** Hojat M, Vergare MJ, Maxwell K, et al. The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School. Academic Medicine. 2009;84(9):1182-1191. doi:https://doi.org/10.1097/acm.0b013e3181b17e55

What is wrong with me?

Timothy Gilligan, MD

Call your doctor
This could be urgent
You never know

The uncertainty feels incendiary
Could this be it?
Will you make it?
If only someone could tell you

You weigh the evidence
Read the tea leaves
No reason to take any chances
Submit yourself to their exam
Just to be sure

Bend over
This won't hurt a bit
It's important to keep things in perspective
Whatever you do, don't freak out.
Everything will be ok
Unless

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Recovery

Rene Aleman, MD

Life is not big enough to withhold everything
desire can imagine.

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The weight of it all

Anna Swenson

I am SO sad. Sad. Proud. Scared. I didn't realize how emotional I would be when I finished. Once I closed my laptop and stepped outside, I burst into tears. It's over. Eight weeks of intensive outpatient treatment for my eating disorder, gone in the blink of an eye. I never knew how powerful it is to connect with people over something that tears you apart. A mutual understanding of the abusive relationship of an ED can quickly build up trust and connection in a uniquely powerful way. I will miss my group. I will miss lunches together over Zoom chatting about our lives, laughing, and talking about the good and the hard. I will miss our group sessions where we learned and grew together. Where we questioned what we've been taught and learned to think differently. I will miss it all. And I will hopefully never be back again. Who would have thought this would be so bittersweet?

I am proud and excited to have made it through. Yet it makes sense to grieve this loss. I learned and connected and nourished my heart, soul and mind. I am losing something that has been such an important part of my life and changed me in ways that I never envisioned for myself. I am grieving leaving behind a group that helped push me forward in a journey that I could not have done on my own.

I honestly can't believe where I'm at. Three months ago, I was in a bad mental space. I got to the point that I didn't care anymore. I had tried for the past six years to heal, and it was all up and down, back and forth – only partial recovery. What was the point of fighting anymore? Wouldn't I always go back to the ED anyways?

I had started med school in a good place overall–much better than college–even if I was still clinging to parts of the ED. But a culmination of many stressors in my life twisted together with ED thoughts the spring of my first year, and I started to stumble. My dietitian brought up the idea of IOP treatment. Was I really bad enough to need that? When I first brought up the idea to my mom and dad, I didn't think I would actually do it and nearly canceled my intake. But my dietitian encouraged me to attend the intake appointment since it was already scheduled, just to see what they'd say.

The night after my intake appointment, I played tug-of-war in my mind, deciding whether or not to pursue this. I knew deep in my gut that I needed to say yes, and I would regret it if I didn't. But I also felt guilty for not being able to get better on my own or with the help I already had. The next week, though, I found myself sitting in a Zoom room with my new dietitian for orientation, facing eight weeks of the unknown.

A few weeks into IOP, I texted my mom and told her that this was one of the best decisions I had ever made. I made so much progress throughout those first few weeks and felt much more full of LIFE.

Every time I think about my IOP group getting together without me next week, the tears well up. I want to be there, surrounded by that safe group of people who understand me on a level that many never will. I'm afraid to go "back to reality," to be thrown back into a world that is diet culture. To stick with what I've learned and know to be true for me. To live counter-culturally and not feel ashamed or guilty about it. I am scared to not have the support of this group anymore, and sad. So sad.

It is lonely to live with an eating disorder in medical school. To experience a disease that in many ways deeply aligns with what we are taught is "good" and "right." To behave in ways that are not only praised and reinforced by society, but even more so by the medical field. I am living in a state of tension and dissonance between my lived experiences and what I am taught. I must make intentional choices in recovery that oppose what has been engrained so deeply into the crevices of my mind. The choices I make daily are different from what the world worships. What is so unique and dangerous about an ED is that while other addictions are stigmatized and carry their own burdens, the disordered behaviors of a restrictive ED are idolized by both society and the medical field. My habits and body had been praised for so long from the outside, while they destroyed me from the inside.

I am hopeful that I can keep moving forward into *full* recovery. I want to be fully free. I have spent too long trying

to do what I have been told is best by the world but not listening to my own body telling me what it needed. The more I learn, the more I realize that as much as you can know about medicine and science, every patient is so different. What my body needs cannot be decided by a medical board that doesn't know me. As someone going into medicine, I know our role is important and we do have the privilege of understanding the body on a deeper level than the general population. But to think that what we learn from textbooks and experience can apply to everyone is naive and foolish. To not dig into the details of someone's life when we are treating them to really understand what is best for *them* is selfish.

I want to be different. I want to be a provider who prioritizes the *health* of my patients. I want to take the focus off weight. I want to stop demonizing foods. I want my patients to know they are worthy no matter the size of their body. I want to know that I am worthy no matter the size of my body. But will my actions as well as those of the few who agree with me be enough when diet culture is all-consuming in the medical field? When we are taught to prescribe diets and weight loss for patients but not to ask about their relationship with food and exercise?

How do I rewire my own brain to align with recovery when I am being taught and told to believe otherwise every day?

I want my patients and myself to be more than just okay. I want us to experience a full, rich and vibrant life. My lived experience with an ED as a medical student has given me the perspective I need to promote a life of nourishment of body, mind, and soul. I want to value my patients as human beings, helping them to pursue health in ways that uphold their dignity and wholeness.

But for now, I just want to grieve ending this part of my life that has put me on a solid path to recovery and given me more freedom than I have had in years. I want to mourn that I won't get this unique experience again, and hopefully will never have to. Looking ahead is exciting, and I'm proud of how far I've come, but I will first grieve ending this chapter of my life.

Breakthrough

Chineme Onwubueke, CCLCM
Class of 2025

Sometimes, it takes truth in the form of light to break us out of the jail cell that imprisons our mind. *And the light shines on in the darkness, for the darkness has never overpowered it* (John 1:5)

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The physician I want to become

Brady Greene, CCLCM Class of 2025

During my internal medicine rotation, I was fortunate to follow a patient from her initial H&P on admission all the way through to the day before her discharge, a period of two weeks. The patient was admitted for further evaluation of unintentional weight loss, having lost almost 100 lbs in 1.5 years (down to a weight of 100 lbs from a starting weight of ~200 lbs), in the setting of chronic diarrhea. Each day, during pre-rounding, I would check in on her. Sometimes, I would get a bit carried away chatting with her (e.g. discussing the terrible diarrhea she had the night before, or how down she was feeling from all the poking and prodding involved in her hospital workup). This would cause me to run late for rounds with my attending. On these days, which was more often than I would have liked, I felt incompetent and like I wasn't contributing to the team.

However, on reflection, I now realize that in all of those instances where I was 'running late,' I was actually establishing further rapport with the patient and learning about her. I would frequently call her granddaughter, who was a family medicine resident at a different institution, and together, we brainstormed how to get the patient to take lovenox for DVT prophylaxis. The patient had stopped taking the medication at one point because she didn't want shots in her belly. We worked together to find a solution that worked for her, and eventually, she agreed to receive the shots in her arm instead.

On my last day of the internal medicine rotation, I went to say goodbye to the patient, and she surprised me by asking if I wanted to go for a walk around the floor with her. I accepted the invitation, and we took a couple of laps around the floor while chatting. The patient was in her gown and diaper, holding onto an IV pole with one hand, while a bunch of electrolytes were being pumped into her to help correct the abnormalities she was experiencing from refeeding syndrome. As we parted ways, she wished me luck in my studies, and I wished her luck with her recovery. She had been diagnosed with celiac disease as the cause of her weight loss, which was an unusual presentation that had manifested in her later decades of life.

As I write this, I am filled with a sense of warmth and happiness, knowing that I took the extra time to listen to and care for this patient during my internal medicine rotation. Rather than focusing on the negative feelings I had about running late to rounds, I now appreciate that some of my most memorable and rewarding experiences as a clinical trainee have been in situations where I was behind schedule. These experiences have reminded me of why I went into medicine and have been incredibly protective against burnout.

I hope this reflection serves as a reminder to me and to other clinicians that, when we feel stressed about being behind schedule, we should remember that these are often the moments when we have the greatest opportunity to connect with our patients and make a positive impact on their lives.

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Lessons in Anatomy

August Culbert, CCLCM Class of 2026

Cleveland Clinic Lerner College of Medicine M2's Mario-Cyriac Tcheukado and Alan Gordillo present anatomic dissections to physician assistant students in Clinical Anatomy PA 502

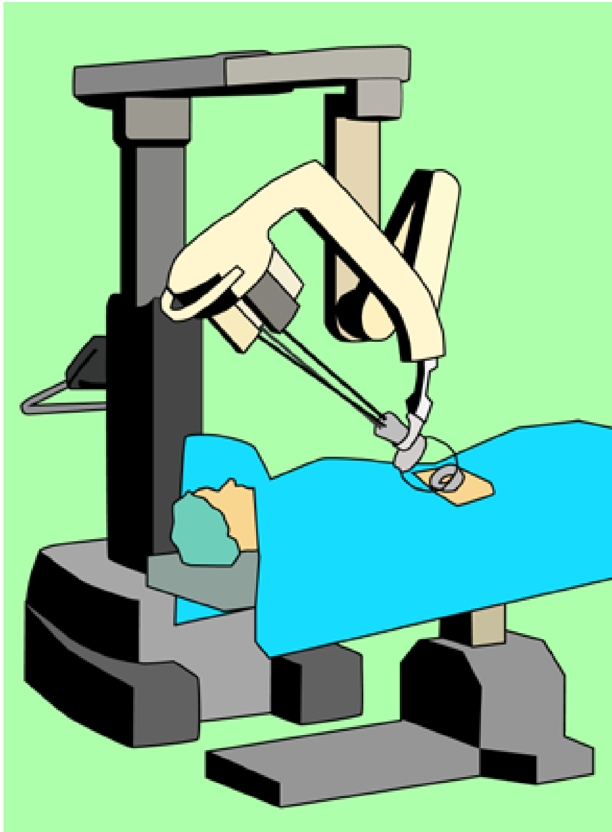
This Is My Calling

Nikita Das

In the O.R., I am a fly on the wall.
Endless standing agonizes my body.
Tears brim in my eyes as I ask myself:
Is this the price of ambition?

Call me foolish,
To not consider other specialties,
To not consider work-life balance,
But I see things differently.

When my entire body, except my eyes, is
covered by sterile draping,
My true spirit shines.
There is no question in my mind.
This is my calling.



Single Port

Roxana Ramos-Carpinteyro, MD

Single-Port Robotic Surgery Pop Art

Oops

Pranay Hegde, CCLCM Class of 2024

Medical students are permitted a diverse library of mistakes, a feat that is nothing short of inspiring. Whether it's omitting an important lab value on rounds or beginning our first oral presentation of third year in the rarely used and deeply disorganized SOPAPOPAS (a.k.a. the "oh I forgot to mention this earlier but…") format, all is ultimately forgiven. "No problem," they say. "You're here to learn."

After all, our mistakes don't really hurt people. The residents and attending physicians often joke that they are the last line of defense despite our attempts to send people to the grave, a sentiment that is morbid but not necessarily untrue. They are the ones who take responsibility for fixing our errors, and who implement the competent action plans. Still, I can't help but recoil every time I forget to suggest a critical test be ordered; a test so obvious that three residents, two fellows, an attending and the patient's family member down the hall whose medical knowledge derives from Season 11 of "Grey's Anatomy" all remembered without hesitation. "No problem. You're here to learn."

In fact, mistakes are so expected that the United States Medical Licensing Exam has even dedicated a percentage of the exam to understanding how medical errors occur. This "Swiss cheese model" is a delicious reminder of the multiple small errors that must occur in tandem in order to impact patient care. However, we can also apply this concept on an individual level. In the clinic, boilerplate phrases are a useful tool for initially interacting with ill or terminal patients, as they allow us to rapidly build rapport with little cognitive expenditure. This can include things like asking about family, commiserating over the commute, or even expressing hope that the patient's visit to phlebotomy didn't end up an unplanned trip to vascular acupuncture. We create these templates sometimes without realizing, and they can be inordinately specific. When I see long-term bone marrow transplant patients in clinic as part of research year clinical duties, I have a habit of commenting on the age of their transplant as if it were a child. "8-year follow-up? Your transplant is a third grader!" It's a comment absurd and adorably simple enough that even the most hardened often can't help but to let slip the tiniest of smirks. And I do it, probably because I know this is the main aspect of the patient's care I can control: how people are treated (and by extension how they feel) when they're stuck with me.

However, it can backfire. Recently, I saw a patient for a 10-year follow-up visit after his bone marrow transplant. Unfortunately, his transplant had failed shortly afterward, and he experienced return of his primary disease. I, the diligent medical student, had read that in his chart and ostensibly KNEW that, evidenced by the fact that I had circled "FAILED TO ENGRAFT" thrice in black ink on the crumpled piece of notebook paper I had shoved in my pocket. Still, perhaps out of force of a habit created by a strong desire to connect with a new person in front of me, I said "10-year follow-up? Your transplant is a fifth grader!" It is difficult to explain exactly why I made the previous statement, as each potential explanation is more stupid than the previous. Perhaps if I had spent less time being proud of myself for deducing that five and five yield ten, some part of my brain would have stopped me from inadvertently celebrating what was essentially the funeral of a "child" that had died shortly after birth. Despite this obvious faux pas…the patient didn't actually seem to mind. He made a joke that he never planned to have kids anyway, a lighthearted reference to the tragic reality of a failed graft. "No problem," he said. "You're here to learn."

We had a pleasant conversation, I obtained the history I needed, we reviewed labs, and the day went on. So why do I still wake up occasionally in the middle of the night, cringing at the time I congratulated a man on his failed transplant? Fear. Fear that despite there being millions of doctors before me and indubitably millions after me, I will be the one who fails to learn from his mistakes. Fear that one day I will oversee people's lives and not know what to do when the feces hits the fan. I know that I am not alone in this fear. Every day, thousands of medical students like me step foot into the hospital, knowing we are capable of some of the most baffling blunders mankind has ever seen. No problem. We're here to learn.

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An Academic Hunger

Sameed Khan, CCLCM Class of 2027

Dawn breaks, its birth a nascent roar
drummed up deep from the depths of the knot
that gnaws on the flesh of my intestines,
its hum thrumming, drinking
the drops off the sweat of my brow,
its maw a void engulfing all self-thought
It wails, and its cries pound
in the beating of my heart who
shoves blood through ungrateful arteries who
wear masks of plaque filled with scorn, but
this preoccupation with Success demands it.
Demands
to nourish itself
on the fragments of my piecemeal sleep,
my bleary eyes stitched open
by the hunger
resounding in every second — this incessant buzz,
this droning hum, setting a score
as I walk in quiet desperation.

Things that you lose

Timothy Gilligan, MD

Your first love.
Your grandfather's watch.
Your grandfather.
Your innocence.

Your blue scarf.
Your orange jacket.
Your favorite shoes.
Your youth.
Your faith.

The illusion that anything is possible.
The illusion that anything is funny.
The illusion that it will all come to mean something in the end.
The illusion that there is an oasis in the desert.

Your car keys.
Your umbrella.
Your hat.
Your mind.

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NIH Building 60 – “The Cloisters”

Maleeha Ahmad, CCLCM Class of 2024

Constructed in 1923 and former home to the Sisters of the Visitation of Washington, the oldest building on NIH campus now houses medical students participating in the Medical Research Scholars Program.

It Was Not a Circle

Danielle Wilfand

On Wednesdays
I go in
Sit in the small room
With the man in a white coat

This time when he asks
A garden
I tell him
Started it in the time
Between one surgery and the next
Planted a hydrangea bush
Beneath my bedroom window

He tells me
Planting is like healing
The surgeon said the incision healed nicely
Edges met nicely
Barely left a scar.
(But nicely for who?)

I say
They cut the bad part out
Each time a little bit more
But each time it comes back
Each time takes a little bit more.
(I wondered if the parts left behind
Knew something was missing)

How many years has it been?
He asks me,
5, 10, 11
(Who's counting?)
Time heals
It all comes back around
To the way it was before
Like a circle.
But it was not a circle

I had another episode three months back
My eyesight gone
Like the last wisps of spring
Came back with the first chill of autumn
In pieces
I still can't see well in the dark
But most of it came back right?
He says
Planting is like healing

I plant only perennials
In autumn, hydrangeas
Wither in winter
But should've
Sprouted leaves in April
Flower buds in April
Should've come back

That night
When I was coming home fumbled my keys
Lost them in the dirt
I knelt and searched
In the empty space where
The hydrangea bush once was
I sat back with tears in my eyes
Dirt underneath my fingernails
Not everything grows back

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Root Cause

Chineme Onwubueke, CCLCM Class of 2025

Like a seed was that event
Down into the earth it was sent
Producing roots that anchored so
And a plant that began to grow

And the human host became ill
A sickness no one could kill
Doctors could not understand
All treatments the illness would withstand

Hope of healing began to die
As year after year came and went by
The body continued to falter
A fatal course that could only be altered…

By knowledge of the root cause

At your end, as your eyes shut closed
Suddenly, a painful memory arose
You were guided to the origin of the illness
And began to see in the quiet stillness

A hidden plant had been growing in you
This plant was a weed, through and through
This weed had a title, Bitterness, its name
Planted in you by that event of pain

But the plant was not the only issue
For the soil was composed of weed-fertile tissue
Your heart permitted growth, to your plight
And the weed made you its slave day and night

That the seed fell upon you will **never** be your fault
But what you can control is the posture of your heart

People may not understand why
Your past manifests itself as an impulse to die
Why your illness fits not into the guidelines of the day
Why your pain manifests in such a strange way

But you are understood by One greater than
this confusion will ever be
This Great One wants you to see:

Part of your healing is in your hand
Refuse to let this weed stand
Feed it no longer the dung of bitterness
And it will shrivel away in its brittleness

The rest of your healing is in My hand
I present to you soil from a new land
It is filled with love for your aching heart
The type of love that will never depart

Indeed, like a seed was that event
Into your earth it was sent
But forgiveness and love shall sever
These enslaving roots forever

You shall be freed
You shall be healed

And you shall know the truth, and the truth shall make you free. - John 8:32

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Bias on the Neurology Service as Observed by a Medical Student

Benjamin George

There are three distinct patterns of bias that I experienced during my neurology rotation. The first was a regional bias for those coming from West Virginia or Kentucky. I noticed some residents would comment about how folks from these states came from lower socioeconomic status, had poor healthcare access in their state, and were more likely to distrust doctors and vaccines, among other things. After hearing this, I even felt myself one time start to ask if something about a patient was related to them being from West Virginia, and the resident in charge corrected me that not everyone was like that from those states. It was a reminder to me that diversity and differences are everywhere, and I should keep my eyes open to treating the individual patient, not the stereotyped background that they come from. Our minds are incredibly quick to grab onto group designations and apply them liberally.

My second experience was how we treat referrals and consults that we deem to be incorrect. First, I had an outpatient preceptor who received a referral that he felt was not relevant to his scope of practice. She had heart problems that he felt explained all her symptoms but was referred from a cardiology office. Before seeing the patient, he complained about how generally we get all these bad consultations, and how he could tell what was going on with this patient. When seeing the patient, he was still a good doctor, but he focused on her cardiac history instead of her current complaint. It struck me that by reading the chart in advance and coming up with an idea of what is going on, we narrow our differential and reduce our ability to help the patient. On another occasion, I followed a resident to an ED consult that the resident felt was silly. The consulting physician did not make it clear what they wanted from neurology. This was because the patient had a very complex medical history, and the ED needed help determining how to best help the patient. Rather than working out a good idea about how to handle the consultation, it felt more like the resident thought about the poor quality of the consultation information and how the patient didn't fit with a neurology picture. Although this was helpful in determining less neurological workups to obtain, it led to an interview that was extra-long, as the beginning of the interview was poorly focused, and the neurology concerns came out later in the interview because of this. Both experiences taught me about the pre-interview bias that can change the way I care for patients. It can be easy to focus on less important parts of the history just to confirm our own bias that this patient doesn't belong in our clinic, rather than working to personally be as helpful as possible to the patient and their current concerns.

The third pattern of bias I noticed during the rotation was in the attitudes surrounding suspected functional neurological problems. I noticed both positives and negatives with regards to this many times throughout the rotation. I noticed many residents who had negative feelings about their patients and talked about how they were intentionally creating the symptoms. I noticed often that they regarded these symptoms as not being real. Many times, they would describe the functional symptoms in terms of how the symptom must be consciously produced to look that way on exam. This outlook was countered several times by both attendings and residents who reminded everyone that one reason for these findings was that patients unconsciously exaggerated them as a cry for help. Many of these patients had a structural neurological problem which they might be exaggerating to make sure they were taken seriously. It strikes me that these are the patients who have often been failed by the medical system in the past, leading to their increasing need to have their problems look more exaggerated. Additionally, some gave the reminder that these patients are truly experiencing these symptoms and they are very real to the patient. These patients often have extensive trauma and developmental disruptions from childhood and even from the medical system itself that play into their situation. Additionally, they may not have a structural reason, but they may be produced by unconscious parts of the brain. These experiences have taught me to be careful and check my automatic reactions to patients and their symptoms, because it can be very natural to blame the patient in these situations. There are feelings evoked by how the patient presents, and being

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aware of these can help, but following these can lead to poor treatment. I found it helpful to remember that even a patient with Munchausen syndrome needs real help, and it is inappropriate to label patients as malingering when there is no clear gain.

Bias comes in many shapes and sizes and is not limited to traditional categories. The biases I saw throughout my neurology clerkship are very common throughout medicine and all too often lead to worse patient care. It is a natural part of how our brains work to create categories and stereotypes or to assume external circumstances for our own failings and internal circumstances for the failings of others. However, when we give in to these natural tendencies, we do not see the whole patient, and do not treat the whole patient. We as physicians should think critically about all our interactions with patients, particularly examining the difficult interactions. Then we must develop the self-reflection required to challenge our own beliefs and give everyone the benefit of the doubt. Often the negative experiences we have with patients stem from us originally.

Student Doctor Syndrome

William Patterson, CCLCM Class of 2025

When I started medical school I thought:
knowledge was fruit.

My gyri awash in their saccharine juices milked from
slides with yellow text on a deep blue background.
I was ever hungry — the body a cornucopia.

As I learned more, the mind turns inward.
Every ache was arthritis or gout.
Bruises or hives took on the patina
of ecchymoses and urticaria.

These fruits fed the beast of anxiety —
heavy weighs the gift of diagnosis on the mind.
Even doctors get nervous.

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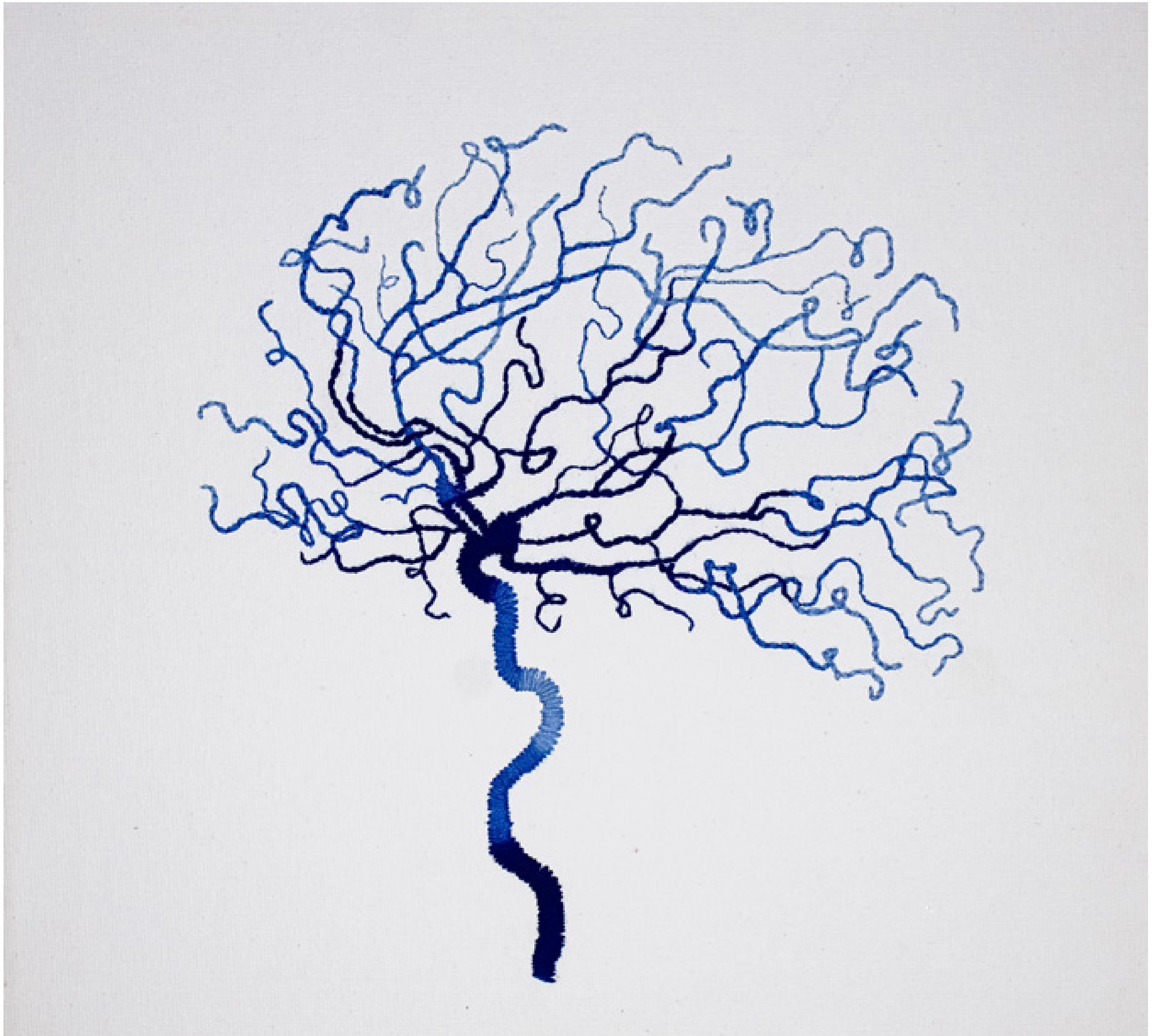

Your Brain on Yarn

Madeleine Blazel, CCLCM Class of 2025

During my rotation on stroke service, I followed a patient to the thrombectomy suite for their procedure. I watched the cerebral angiogram, entranced, as contrast spiraled through the vessels and perfusion to the brain was restored. Using embroidery, I wanted to depict how some of the most critical blood vessels in the body are, at the same time, so impossibly delicate and intricate.

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COVID Cutting Board

Tom Abelson, MD

March 16, 2020 was a clear and chilly 25˚ as I headed before sunrise for a day of surgery at the Cleveland Clinic Beachwood Family Health and Surgery Center. At midday I headed to the Chagrin Falls Family Health Center for an afternoon clinic.

A frustratingly long stoplight held me up on Chagrin Boulevard. Suddenly I became aware of heat emanating from my body and face. Sweat seeped from my forehead dripping into my eye. My heart beat like a base drum. From fever or fear? We were only a few months into the COVID-19 pandemic and even though we did not entirely comprehend the utility of masks, we did recognize fever as an early sign of COVID-19.

As the light finally turned green, I continued driving, debating whether to continue my journey to Chagrin Falls or, as I knew I should, call the COVID hotline. I pulled into a parking lot, wiped the sweat from my forehead, and took a sip of water. My fever deepened. My heart pounded with vigor. I restarted the car and moved it to the shade of a tree to make that fraught hotline call with less discomfort.

A tremor shook my hand as I searched for the hotline number. My mind raced. Suffocation. Intubation. Profound loneliness. Did I put my password document where my family would find it? Could this just be the flu? Will my wife be able to see me since she takes care of patients with COVID-19 in the hospital?

Suddenly my brain lurched to attention. That dark, frigid morning I had put on my down coat, turned the car heater up to 70˚ and put on my gloves before gripping the cold steering wheel.

Now, four hours later, the temperature was 52˚. The sun was beating into my car through closed windows and the sun roof. The heater was still set at 70˚. I was wearing my down coat, for God's sake!!!

I killed the heater, opened the windows and sunroof, removed my coat. Within seconds my COVID-19 melted away. My panic evaporated with the sweat on my brow.

Breathe…

Despite health, the fact that I had panicked stuck with me, disappointed me, scared me, moved me.

That night I wrote an email to each of my young grandchildren, couched as birthday messages, just in case I could not do that in the future.

That weekend I retreated to my woodshop and created a cutting board, a COVID Cutting Board. The broken connection between the two narrow spines of curly maple symbolizes the damage this virus can cause, breaking our bodies or whiplashing our psyches.

We have used that cutting board every day for almost three years. I pine with the desire to create a Post-COVID Cutting Board with a reconstructed, if fragile spine. Is now the right time?

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Rugged Reflections

Abdelrahman Rahmy, CCLCM Class of 2024

Amidst nature's grace
Wind blows bringing sweet solace
Reflecting in peace

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Recovering Ourselves

Kathleen Franco, MD

As a young adult, I viewed recovery as what happens after occurrences throw a life off-balance; perhaps it is an illness, an accident, an addiction, or a family loss. Then recovery, hopefully, will follow, requiring differing lengths of time, maybe a day, a week, a month, or years. As I've aged and learned from patients in my practice, I've extended that timeline to generations. We also know that recovery may not occur at all, at least in a specific person's lifetime. However, if we take the long view of generations, there is reason to believe with hope.

Recently, I found a book called *The Pendulum: A Granddaughter's Search For Her Family's Forbidden Nazi Past* by Julie Lindahl. For reasons not initially understood by the author, she found herself struggling through a life of shame. It is one of many examples showing how three or more generations can pass before movement toward recovery can occur. Consider families who were enslaved for centuries and generations with no hope of recovery. Do we even know how many generations it took to truly recover once they were freed? This topic deserves much more than a short essay but is one I hope you will ponder.

In the 1970s, family therapists began using diagrams to study what was causing differences within families and following changes from one generation to the next. By 1986, Monica McGoldrick and Randy Gerson wrote *Genograms in Family Assessment*. The schematic diagrams in their book documented medical history, family relationships, psychological patterns, addictions, divorces and many other factors. The book included not only examples of patient families, but those of historical figures, including famous politicians, entertainers and artists. It was not hard to find repetitive patterns of addictions, suicides and divorces. There are many other resources that look at criminality or leadership over generations too.

Perhaps *Genograms in Family Assessment* was the beginning of my awareness of how long it might take for recovery to occur, or even to begin moving in a healthier direction. Not only did I begin to map out the genograms of my patients, but I also thought it was important to put my own family under the microscope to see what I could learn. As with my patients, I also found some relatives unwilling to answer questions about past generations, particularly anything that might have a negative connotation. Divorces, infidelity, mental illness, alcohol abuse, mysterious runaways, and deaths are amongst those discoveries in the family tree. I learned about those who married and didn't tell their families for over a year or those who had post-traumatic stress disorder and never recovered after World War I. Those circumstances had been very painful and much had been done to attempt to bury them. I could find repetitions of some behaviors in later generations. What if they had known about their predecessors? Would these behaviors have been preventable?

Knowing something and doing something are totally different beasts. Let's take, for example, an overworked, stressed physician who tells their patients one thing and behaves altogether differently. "For you to stay healthy, you need to exercise for X minutes, X days a week." How many physicians in my generation said that, but didn't do it themselves? Countless. Likewise telling our patients to get seven to eight hours of sleep yet pushing ourselves to work on three to five hours per night. I am guilty of these and many other examples. Maybe my patients didn't see it or perhaps they suspected it. My children certainly saw it. If I can't recover for myself, how can I expect them to believe it is really meaningful? So, to recover health, I needed to put my behavior where my mouth was.

Looking back more than three generations on both sides of my family, no one took care of their bodies. Instead, they valued hard work and service to others. Perhaps they didn't expect to live long. Having dessert twice a day, walking as far as you have to, and eating snacks were the norm. Of course, medical knowledge wasn't what it is now, but I can recall my grandparents saying they shouldn't have that extra dessert but eating it anyway. Intellectually, I knew that it was not very healthy. They died young, at age 59, perhaps enhanced by nightly ice cream. As I age, I am trying hard to revise my behavior to let my own grown children see what I value and what I want for them.

Gratitude brings happiness and serving others brings satisfaction, a sense of accomplishment. I do think I see these characteristics extending through many generations

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before mine. I see it also in my children and now even in my two older grandchildren. Do we sacrifice ourselves in the process? When does serving others begin to cross over into harm of the self? I know it when I see it in another human being, but I only feel it strongly within my own life when I have my back to the wall and have to make drastic changes. The problem for me was that I could put blinders on like a plow horse, as my grandmother would say. I learned this from my parents and grandparents, who likely learned it from many earlier generations. Only if I was at the edge of the proverbial cliff would I ask myself if I could continue to live this way. Only when I wasn't certain that I could go on, or when I was fairly certain that I couldn't, would I seek change. What changes had to be made? Where did this fall in my priority list? Were there to be sacrifices or painful consequences? And would they be worth the needed changes? My survival of body and soul, the safety of my patients, and the physical capacity to care for loved ones were the only factors that ever tipped the scales for me. At those points, I made the steps for personal recovery outside of what my genogram would predict. I could again make choices that physically, mentally, and emotionally put me on a better path. There are lots of circumstances and people that pull us toward unhealthy choices. There are unwritten messages that are passed down that seem more meaningful or valuable based on behavior that we have observed. Maybe we have to re-examine them. If we don't, our children and our students may never have a chance to reflect and re-examine their own choices. We are not locked into our genograms. As a parent and mentor, I hope to encourage my children and my students to reflect and re-examine. I want them to know they are worth it.

Mountain

Johanna Goldfarb, MD

The mountain is a symbol for equanimity or balance. Equanimity has been described as a bird with wings of Compassion and Wisdom. The symbol is used as a focus for meditation. Mine is imagined and made with embroidery on cloth.

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Meditation for a caregiver

Johanna Goldfarb, MD

May all beings be safe and protected, be understood as individuals, and know love.
May all beings be awake to each other's experience.

May we recognize our uniqueness and limitations: enabling us to use compassion and wisdom in our actions; responding to each person who seeks our care with respect, kindness and concentration, and,
May this allow each to feel recognized, safe and to trust our care.

May all beings have enough, including time to rest and to experience silence.
May this result in lives lived in peace, with love and equanimity.

Note from the author: This is a form of Metta meditation, a traditional Buddhist meditation.

If I slow down

Jason Nasser, MD

The light blinds me
As it passes through the tree lines
Catching crazed eyes
How long have I been at this?
What was my destination?
My mind wanders
My legs are tremulous
But my pace is relentless

The only sound I hear
Is rumbling and wheezing
Coming from my own lungs
Through an open mouth
That can't get its fill of air

The ground hardens with every step
The noise grows louder with every breath
The air becomes thinner with every beat

I look ahead
As I tread my last peak
I cannot see past it
I tell myself it's my last peak
I feel warmer
I'm getting closer to the sun
Is it there
Or was this another false summit
I'm tired
I wonder if I can trudge one more
My legs are tremulous
My breath is coarse
My eyes may as well be closed
As my direction is unchanging
My stride remains the same
I'm tired
I hope this is my last peak

As I aim for the sun
I hear whispers
Coming from the trees
What if it's not a mountain
Or the sun
What if it's the edge of the world
If you don't slow down,
You could fall

I am tired
My legs are tremulous
My breath is coarse
If I slow down,
I will fall
Thud
Foot meets stone
And I fall
Rolling down the hill
Hearing twigs breaking
Or is it my bones
Feeling everything
Disappointment, chagrin
Anger, frustration
Confusion, pain
I lay motionless
Shackled by gravity
Then, unexpectedly
I am flooded
By gratitude
By relief

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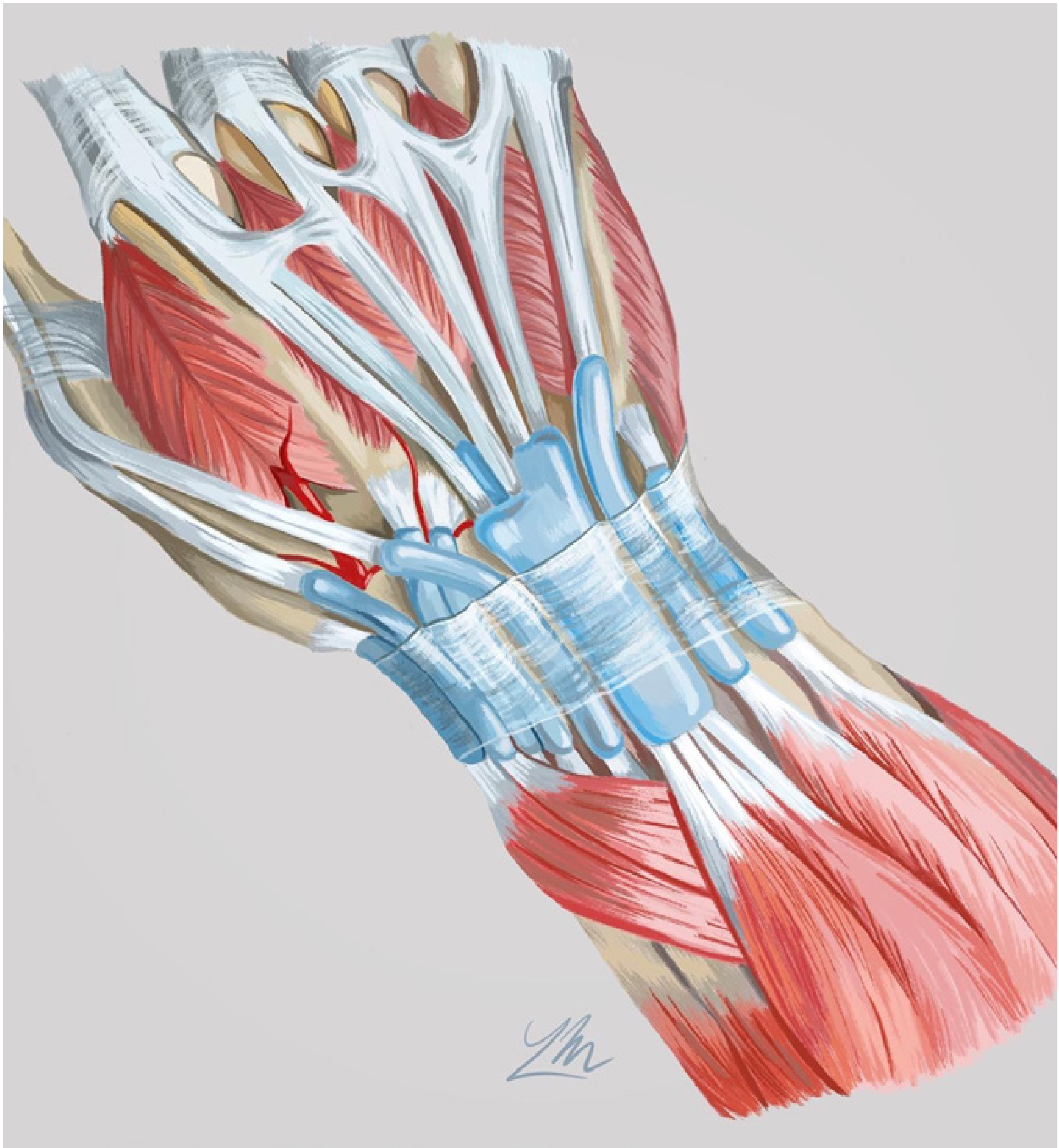

Extensor Tendons of the Wrist

Lianne Mulvihill

An anatomical drawing depicting the extensor tendons of the wrist.
The six extensor compartments of the wrist serve as tunnels for tendons to pass from the forearm to the wrist. The extensor retinaculum overlies the extensor tendons at the wrist.

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Family Caretaking

Serena Lee

"I'm not going to get married!" I spoke emphatically to my grandma (할머니/halmoni) in Korean, as I walked her back to her bed. As with many older concerned relatives, she had asked for the nth time whether I had a boyfriend and if I was going to get married. I always gave the same answers. I don't have a boyfriend. I'm not looking for one. I don't know if marriage is in my future.

My answer was different as a child. I remember telling 할머니 that I had hoped she would stay alive so she could watch me get married one day. She would often remind me of this answer. It's a fond reminder of how much I loved her growing up, how much she and my grandfather intimately took care of me throughout my elementary school years.

But my relationship with her grew complicated during college. My mom confided in me of the struggles during her marriage and how her mother-in-law, my grandma, abandoned her when she was being mistreated by my father. 할머니 had taken my abusive father's side, staying silent and distancing herself from our family's issues. I was furious. I stopped answering her calls as often. One time when I did pick up the phone and confronted her about what she did, she feigned ignorance. As I was already struggling to process my experience with my father and his anger issues, this only made things worse.

I was arguably still on that journey of healing and processing when, in 2021, the roles of caretaking were reversed. My grandmother was nearly blind, only seeing shadows. She had multiple heart, knee and hip surgeries, and needed a walker. She was living alone and widowed in a senior apartment until she fell one day, sustaining a brain bleed and needing even more surgery. It was a wonder to our family how she was, for the most part, still mentally intact. My parents subsequently moved us to a bigger house to have her live with us.

At first, we thought we could take care of her ourselves. But after her discharge from the hospital, she needed significant help in every basic function, often needing assistance throughout the night as well. My mom eventually got severe nausea and vomiting from the lack of sleep. It became clear as my parents and I all still had to work and take care of our responsibilities that we needed to hire a caretaker.

Here is the summary of the journey to find a caretaker:
The first caretaker was a volunteer through her church program. It was free, she was great, but it was temporary.
We found another caretaker, but she proved incompetent. Once, she left our front door wide open and our dog ran out. I often had to be home to do damage control, so it didn't make much sense for us to have an extra person we had to pay for. Medicare paid $15/hr minimum wage for caretakers and we felt we could not afford to pay more. She eventually asked for higher pay. We couldn't afford it.
We were calling around, but finding a Korean speaking caretaker who was willing to take the minimum wage was hard. Every caretaker was asking for much higher than our budget, and we could not give it to them.
We finally found someone who was not Korean, but had Korean relatives so she at least respected the culture. She consistently went above and beyond. Our family was relieved. But within a month, a family issue came up for her and we never heard from her again.

Then came the day my mom asked me to be 할머니's "official" caretaker as a side gig when I wasn't at work in the hospital or volunteering at the school. She would even pay me. Thinking this might be a good opportunity to mend a broken relationship while getting practice with bedside manners, I said yes.

I was enthusiastic in the beginning of my role, but that quickly faded. The more I spent time with her, the more I started to experience a whole host of complicated thoughts and emotions. For one, my life became a lot more disjointed. Because of her blindness, she constantly called for me throughout the day to change the channel on her TV or just to ask a random question. Personal life and caretaking felt like an impossible balance to strike. She would forget I still had remote tutoring sessions and medical school interviews, and would call for me relentlessly until I would have to interrupt my call and run downstairs to see what she wanted. And of course there was a nagging feeling every time of, okay but what if this is an actual emergency? But it often was not, and we could not find a system with appropriate boundaries.
I could also tell she felt purposelessness being bound to her room. It could have been her desire to exercise autonomy or simply boredom, but I would sometimes find her in a

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random, “forbidden” part of the house where she had fallen on the floor, after which I would scold her for wandering.
I felt compassion yet helplessness for her situation. I researched online for ideas to help her, but resources were either catered to the blind or to the physically disabled, but rarely for those affected both ways. She would also say triggering words that I could tell were trying to encourage and help me, but were instead so painful and anger-inducing because of how much it reminded me of her enabling my father’s behavior and tendencies when I was growing up.
On top of all of that, I could tell she always felt bad for burdening me.

Eventually, the tension and shame had reached a breaking point. I told my mom that I was sorry but that I don’t think I could do it. Can we please try to find another caretaker? I mean, I’m leaving for medical school at some point so we need to find someone else anyway, right?
A part of me was relieved when it came time for me to go off to school. There was no doubt I loved my grandma, but it was hard and complicated and I was glad that I no longer had to come face to face with this specific struggle for a while.

But that internal conflict stayed with me until her last days.

During winter break of M1 year, her health had been more or less the same until she had a dental appointment and some lunch with my parents and her friends. Since then, she declined rapidly for unknown reasons. When I went to go say goodbye before going back to school, I was shocked at her state of being. She was stuck in bed, barely able to speak, and gasping for air. As my parents didn’t seem to understand the gravity of the situation, I emphasized the urgency: “She needs to go to the hospital.” My mom finally got it. She called my dad and brother for help while I called my Uber for the airport.
But when it was time for me to leave, she shocked me once more. In her weakest state, she gave everything she had to sit up and squeeze my hand. She then grabbed my arm, pressed her head into it and said, “This is Serena, I must remember this.” Overwhelmed, I was already in tears as she prayed for me. Hearing my tears, she said something along the lines of “stop crying, you don’t have to be sad because I’m going to a place full of people I know.”
I told her saranghae (meaning I love you in Korean) twice. After the second time, she said “saranghae, I love you.”
I knew deep down that saying I love you in English was representative of her efforts to love me throughout my life, trying so hard to help me thrive in this land that was foreign to her, but home to me. In that moment, it was as if all of her failures to love me, and my own failures to love her, were forgiven by each other. Saranghae, I love you.

A Taste of Home

August Culbert, CCLCM Class of 2026

Kodak Gold 200, 35 mm, Canon FTb – Boston, MA

quality of life

Olivia Dhaliwal

biologists define six tenets of life:
cellular organization
reproduction
growth and development
energy use
homeostasis
response to environment
and
ability to adapt.

doctors have two tenets of death:
cessation of circulation
and
cessation of breathing.
the avoidance of these is the goal of most medical intervention.

i am curious about
how each patient defines life
what is life-giving?
what is life-saving?
what is life-living?
is it
breathing well enough to partake in cheeks streaked pink
fleshy watery melon tears dripping onto picnic tables
evaporating rapidly in relentless august sun
or
legs strong enough to carry for days meandering the forest
with an empty mind patient quiet enough to notice small
beings scurry light filter through each twig moss creep
slowly across granite surfaces bounding the path you follow

i want to save a life
in time
for a life to be lived.

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Magnolia Warbler

Philip Wang, CCLCM Class of 2024

Warblers are known for carrying themselves in a horizontal body position. I couldn't help but to think that this guy was feeling high and mighty about himself!

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Life Lessons from Drosophila Melanogaster

Aishwarya Gautam, MSc

The sudden appearance of drosophila melanogaster, the common fruit fly, in a house or, say, a 1,500-square-foot apartment, is nothing short of remarkable. Once cited as evidence for the theory of spontaneous regeneration due to their habit of emerging out of nowhere at all, we now know that fruit flies do obey the laws of physics. But their inner thoughts, their fears, and more generally, the driving force of their lives remain shrouded in mystery.

It was in the lingering heat of summer in September that the first few fruit flies appeared at 830 W. Montgomery Ave., Apt 312 in Bryn Mawr, Pennsylvania. So small, so quiet that we hardly noticed them in the bright hours of the day.

One became two became twenty became fifty, the trajectory of their growth outpacing the time it would take to create a graph of said population, concerns of resource distribution and overpopulation clearly not weighing on their tiny insect brains. They gathered in droves, establishing their territory: the windowsill, the high, white-painted cabinets furthest from the kitchen entryway, the door frame.

In our belated recognition of a problem that we should have seen coming for days, we waged full-on war against the flies. The internet was consulted. The recommended traps were assembled: a shallow bowl of wine with a few drops of dish soap to cut the surface tension – the equivalent of a sand pit for those wretched, sweet-loving creatures. Another, more humane “collecting jar,” became a favorite of mine: a glass jar with plastic wrap over the top, punctured by small fruit fly-sized holes, holding the most coveted of treasures: a rapidly decaying apple core.

We set the traps and forgot about them for days. Every once in a while, I peered through the glass to see what the corralled fly population was up to. I got so close that I could see their red, orb-like eyes, the translucent brown bodies darting along seemingly aimless paths. At certain times of day their activity was abated; instead of flying, they walked, their invisible little feet carrying them across the length of the apple core that somehow never seemed to get smaller.

As more and more flies amassed, I began to wonder why they didn’t simply leave the same way they had come in – the holes were clearly big enough for them to fly through. “These fruit flies are astonishingly dim-witted,” I thought. But as the days passed and I saw no change in their behavior – they remained as industrious as ever – I concluded that maybe they liked it in there. Maybe they didn’t feel any reason to leave. They had food, air to breathe, their fruit fly brethren for company. Hell, they could even reproduce and make more of themselves if they got lonely.

In a way, I started to envy those creatures. Subject to the vicissitudes of the inhabitants they ended up cohabitating with, they seemed completely unfazed, determined to keep on keepin’ on.

When it came time to release them outside, I wondered what they must have thought in that moment. Did they feel scared? Excited? Or only rapid and complete acceptance of their new condition?

If I could speak to them, I would ask them for advice. Maybe they could teach me to be good and busy and happy in the confines of a sealed-in space, to not even see it as a sealed space, to not feel constrained by the seconds of the day and the limits of mind and body. I would ask them how to simply exist for some time on this Earth.

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Ghost

Maeve Pascoe, CCLCM Class of 2024

Why is it so hard to see you
You're not a ghost, yet
Blood still rushes through your veins back to
a beating heart
But something about the way you remind me
That it's not just your beats that are numbered,
Makes my superior rectus feel like it's lifting mountains
Rather than my gaze to meet yours

Where the Light Enters

Mihika Thapliyal, CCLCM Class of 2025

where the light enters, i am faceless.
i never start out that way.
when i walk through the doors, i am
embellished with identity.
here, a watch my father's father wore.
over my shoulders, the coat you bought me
last diwali.
around my neck, the tie my wife fixed before
i walked out the door.
on my finger, my promise to her.

none of this follows me to the room where
the light enters.
while i lie here, my clothes sit neatly folded
on a bench,
strands of fur sprinkling forgotten floor,
my watch and ring alone in a plastic tray.

where the light enters, i am but a figure,
adorned in white and blue checkered cloth
coarser than the burlap bag full of rice in the
pantry.
a plastic band chafes the skin where soft
leather once was.

where the light enters, i am still, and it is
quiet.
sometimes, i hear the soft shuffle of hands
on a clock,
but i know this is a whisper's whisper.
i picture the shadows sliding past beyond
the glass,
but i cannot see beyond the mindless hum.

i await my own return.

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CPR in an Emergency Room

Sameed Khan, CCLCM Class of 2027

If we gave these walls a tongue,
what would they say?
Silent sentries as they are,
witness to countless tears of grief
layered one over another,
a gently suffocating sediment
laid over the faint whispers
breathed from the fading lips
of the departed

Do they weep or do they smile
when we pray
cross-fisted devotions plunged deep into her sternum
hope laid out in palm-faced fury
grasping for gossamer threads of breath
live, live, live
we yell it at 100 beats per minute
and 2 inches deep
And the priest comes, brandishing his ritual hymns
Clear!
And we arrive in unison to hold our breath
like hers
to share in her life-death for an infinitesimal moment
All future, past, and present held in stasis
Bound together by expectation

Life again, life again
we hum
in tones of epinephrine and atropine

Life again, life again
stamping it into her sternum

Life again, life again
Its hope held in the whine and shock and rise and fall
prayers to a body with no reply

if we gave these walls a tongue
what would they say?

high output heart failure

Olivia Dhaliwal

once upon a time
i would grow extra limbs
palms wide, grasping (or gasping?)
ready to hold extra spoons.
glutton for work.

in states of unrestricted growth,
a body too greedy for its own organs is doomed to wither,
slowly.

you have two hands,
ten fingers,
one four-chambered, palm-sized, heart at your center
you were meant to live within these magnificent means.

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Bones
Timothy Gilligan, MD

The White Coat or the Suit?

Surendra P. Khera, MD MSc

It was one of those summers you remember distinctly; I had just been offered the Chief Medical Officer position at a large inner-city health system. After spending over six years as a busy clinician, I felt a little unsure as to what this could mean. "Out of the frying pan and into the fire!" quipped one colleague. "I hope you like cold sandwiches served with stale coffee for dinner," said another.

Of all of the comments, there is one that still plays on my mind, because of all the possible future scenarios that I had mulled over, this was not one that I had considered: "So will it be the white coat or the suit?" It is now fall, almost seven years later. I look at the starched, clean white coat hanging in my office, and I try to recall the crumpled, discolored white coats with bulging pockets from my clinician days. Pockets full of notes and algorithms—evidence-based guidelines drafted by the wise clinicians before me and endorsed by countless august medical committees—while the busy clinician in me went about taking care of the seemingly endless number of patients on my daily schedule. I will take care of patients and let someone less busy than me take care of the "administrative stuff," I would think. I think of this today even as I type an email to my team: "Physician Productivity Metrics."

I grew up in a busy, crowded metropolis of 12 million people, haphazardly sorted by destiny into the haves and the have-nots and the in-betweeners. This is the city where Mother Teresa wiped the wounds of "lepers" on the streets in the shadows of temples and skyscrapers, amidst the relentless and seemingly uncaring march of life that defines so many of the world's cities. It was called the City of Joy by foreigners who spent a few weeks there to fill their karmic bank accounts before heading back to their comfortable, orderly first world lives. We who lived in this city did not understand what the city had offered to these tourists to deserve that name, just as we were oblivious to the fact that we were in the presence of a future saint!

She would walk around our school grounds deep in conversation with a Jesuit priest who also happened to be my English teacher and soccer coach, talking about how to organize the fight for the rickshaw pullers' rights as the government clamped down on them. We would kick the soccer ball around and sometimes she would almost trip on it. She would then hold it with her feet and in an awkward rotating motion kick it back to us. This would happen many times and each time we would cheer at this quirky and kind nun. We never paid her much attention, and we were never quite sure as to why all the newspapers and politicians kept arguing about whether this Albanian nun in her revolutionary habit of a blue and white saree was really a blessing to the city or someone just out to convert people to Christianity under the guise of charity. All we saw was the kind, patient face of a nun who never tired of us kids kicking soccer balls into her path.

Now here I am many years later, sitting in my office and listening to the plight of a physician whose mother is dying in the ICU. "I sometimes worry that you don't get it anymore, Sunny. I think you need to come back to the frontlines and see how things work or don't work."

"The White Coat or the Suit?" It is back to that same haunting question.

An artist was interviewed on NPR the day Mother Teresa was pronounced Saint Teresa of Calcutta by the Vatican. She had worked closely with Mother Teresa for over 34 years and had painted her portrait many times. The interviewer asked her about her favorite painting and she said, "This one here, the one without a face." The painting was of Mother Teresa in her signature blue and white saree, the ends of the garment framing her face as would a traditional veil. However, there was just a blur where the facial features should have been. The painter recalled showing this to Mother Teresa who looked at it and asked, "Where is my face?" The Mother then laughed, took a pen, and wrote "God Bless You, Mother" at the bottom of the picture. No face, just a faceless blur of blue and white, memories of humility and compassion. An autographed selfie of a selfless life.

So, you see, kindness, caring and compassion need no face and no uniform. They need no race, no religion, no gender, no ethnicity, no country, no walls, no paygrade, no birth certificate or tax returns. They need no White Coat, nor do they need a Suit. They just need caring purpose.

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The sick we tend to need only feel our compassion and hear our caring voices, leaving convoluted discourses to Suits and White Coats in polished board rooms and to the theologians, priests, rabbis, pundits, and imams bent over their holy books since time immemorial.

The White Coat or the Suit? The question seems quieter in my mind.

I reach for my stethoscope and head to the bedside of the physician's mother.

Lucky Me

Alexander Richards, MD

A few years ago, before finalizing the blueprints for the new wing of the hospital, the administration generously surveyed every employee about what changes they would most like to see. The residents at the time were unanimous in their response: a nicer residents' room. In the old residents' room, the windowless cinder block walls were painted with a thick rubbery coat of white paint and remained free of any posters, paintings or personal memorabilia. The bright white fluorescent light spat forth a headache-inducing glow that made any stay longer than 10 minutes unbearable.

The fishbowl, as it is now called, was the new residents' room. Four glass walls in the middle of the emergency department. It was the perfect example of how good intentions can have bad outcomes. The architects recognized that windowless rooms can be claustrophobic and had the genius idea of making the entire room out of glass. What they didn't foresee was that now every patient had access to a resident with just a few knocks on the glass. Lucky us. It seemed like every time I sat down on the couch for a moment of relaxation, a patient would tap on the glass, peering in at me. They would inevitably ask for some more Jell-O, or how they could get Uber Eats delivered to their bed. Not the problems I had envisioned solving as a newly minted MD. My stomach growled as I made my way back to the residents' room after fulfilling one such request.

I swiped my badge and entered.

"Man, you look tired," one of my co-residents said from the couch.

"I am. I'm ready to get out of here."

"Got any plans for the weekend?" he asked.

"Just excited to see Maggie and sleep," I replied. "I haven't been home since Sunday."

"Damnnnn. I've never done more than five days straight," he consoled me. "It has been brutal since Joseph left."

One of our co-residents had dropped from the program the previous month and everyone had to fill in for his absence. It didn't help that he and I were supposed to be paired together this last month for our trauma rotation.

"I know. I guess if we can get through this, we can get through anything."

He nodded in agreement. My stomach growled again.

"Hey, you got anything to eat?" I asked. "I'm starving and the cafeteria is shut."

"Nah, sorry, bro. I'm fasting today."

"I don't know how you do that."

"The mirror keeps me honest," he said with a smirk that suggested he was joking but told me there might be a deeper truth to it. "Maybe try the vending machine?"

"Ahh, good idea," I said as I slung my bag over my shoulder.

"Have a good shift."

As I made my way down the hall, I checked my phone. It was 11 p.m. on Saturday night. Since getting married, Maggie and I had never been apart this long. I couldn't wait to get home and sent her a text letting her know I was on my way.

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The vending machines were tucked into the hallway near the exit. A draft of cool air sent a chill down my spine as I surveyed the rows of candy bars and chips. I always wondered why hospitals were stocked with junk food. Was it a twisted way of keeping their customers coming back? I punched in the code for a bag of chips, my long-time vice, and tapped the payment system with my phone. Nothing happened. I tried again with no luck. After the third failed attempt, I squatted down on stiff knees and a sore back and read the little screen. Network Error. Just my luck, I thought to myself. Technology always seemed to fail me when I needed it the most. I rifled through my scrub pockets to no avail and dug my wallet from my backpack. I peeked into the wallet and miraculously found an old two-dollar bill I had gotten for Christmas last year. Tommy Jefferson smiled back at me with encouragement, and I inserted the crumpled bill into the mouth of the machine only to realize I was still short. $2.25 for a bag of chips?! I groaned in defeat. I didn't know if I was more upset that they charged so much or paid me so little. I was about to leave but then I saw the coin return slot out of the corner of my eye and was overcome by a memory from my childhood.

I was eight years old. It was Christmastime in New York City, and my family, uncles, and grandparents were making our way to see the Big Apple Circus. Our progress was slowed not by the dense holiday crowds, but because my Grandpy stopped at every single phone booth to play what he liked to call the New York City slots. Free to play and always a chance to win. He was a master of the machines; whether it was a button or a lever, he knew how to work the coin return. Almost always there was nothing, but every once in a while, he hit the jackpot! The glorious clinking of a falling nickel and the smile on his face as he held up his winnings were vivid in my mind. Showing off his winnings, he would always say, "Lucky me."

The memory brought a smile to my face. Following in his ways, I then pressed the coin return button on the machine and was surprised to hear something fall! I reached down to collect my prize, a dirty old quarter. Just what I needed. "Lucky me," I said to myself.

I fed it back to the machine and watched as the corkscrewed arm slowly rotated and released its grip on my bag of chips. The bag fell against the glass and stuck. My stomach growled again. Are you kidding me? I thought to myself. I gave the glass a nudge with no luck. A harder push against the machine and the bag moved, but not enough. The bag stood still, mocking me. On another day, I would've thought this was some higher power telling me that I didn't need this bag. Doing what I cannot do for myself. Not today though. I'd been in the hospital for six days straight. I'd barely slept and hardly eaten. All I wanted was a bag of chips for my drive home. I leaned my weight into the machine, lifting its front feet off the ground, and right at that moment someone shouted from down the hall. Startled, I looked over my shoulder. Were they yelling at me? Right then a gurney blasted through the door with a screaming body covered in blood upon it. Paramedics and nurses shouted in all directions. Another bed followed and a third after that.

"We need all open ORs right now," an attending from the emergency room called out. "Multiple gunshot wounds and heavy blood loss."

Adrenaline filled my body and instinct took over. I didn't see that the bag of chips had fallen. I didn't notice my phone buzzing in my pocket. I didn't see the text from Maggie, See you soon xoxo. I ran after them straight to the OR prep room and started scrubbing in.

A patient, awakened by the commotion, made his way to the bathroom and walked by the vending machine. A bag of chips resting in the tray caught his eye. He looked up and down the hallway for its purchaser and saw no one. He reached in through the flap and grabbed the bag of chips. "Lucky me," he said to himself.

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The Rust Belt

August Culbert, CCLCM Class of 2026

The Gates Mills Railroad Bridge, constructed in 1899, was part of a 33-mile line connecting Cleveland and Chardon, Ohio in Geauga County. It supported the residential development of former farming communities, which were not well supported by steam railroad service. Today, the bridge remains as a pedestrian crossing in the center of the New England-like village of Gates Mills.

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Spark

Rene Aleman, MD

It takes no more than a single spark to start a heartbeat.

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sanguine

Alison Zhao, CCLCM Class of 2026

3pm with the hematology consult service
we go see a woman who bleeds after chemo
how do we explain to someone who craves life
that living is killing her alive?

gauntlet thin face parallel to stick-straight bob
rubbing her arm where purple blotches
bloom like a cartographer's mistake
across the bleeding canvas of her leathery skin

does she know what's happening?
i guess i'm here because
my Ma had sick blood too
heredity, i scribble in my notebook
in my culture, they say
blood is thicker than water

looking into her eyes, flickering blue
in the wide-awake hospital lights
i see despair, hope, hunger –
your kindness will sustain my life.
her pulse vibrates through her AV fistula –
thrum-thrum, thrum-thrum
blocks out the deafening wails of so many
IV pumps and monitors,
waiting to be attended to so
they can sustain life.

we reassure her we are doing everything we can
this can happen and we are sorry
recovery is not linear but
this too shall pass
i want to squeeze her hand just enough
to convey comfort without bruising her –
do no harm, as they say
do what you can, as they say

as we step out into the hall, i get a call
everything hurts again
it is my own Ma
bedridden after spine surgery
soft words from a hopeful daughter
are the strongest painkiller
in my culture, they say
blood is thicker than water
recovery is not linear but
this too shall pass

time and again we traipse on into the unknown
full of silent questions but
comforted by the shadow of progress
we do not know but we do no harm
and that is enough.

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Wood Stork

Philip Wang, CCLCM Class of 2024

The wood stork serves as an indicator species for the health of the Everglades ecosystem. Its noble stature in this photograph embodies more than just elegance; it stands tall as a living testament to the healing resurgence of the Everglades.

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Don’t Postpone Recovery

Kathleen Franco, MD

Years ago, I remember evaluating a young woman in the ICU. She had an extensive history of substance abuse and dependency and had been referred for therapies and treatments over and over again. Crystal meth had left her veins scarred forever. From her neck to her feet, there was evidence of injections and attempted injections. It was sad to see the results of these attacks on such a beautiful body.

We talked about her current life and her past. Her current life was full of hope. She was 8 1/2 months pregnant and had recently married her boyfriend, the baby’s father. He wanted her to get treatment for her substance abuse and she was committed to doing that. She felt having a new husband who loved her, and soon a new baby who needed her, were better reasons than she had ever had to stop using drugs for good.

Her past was filled with loss and neglect. Her mother couldn’t provide for her and resorted to selling drugs, landing in jail for extended periods of time. Drifting from one relative to another, placed in foster homes, and then aging out, our patient was led to believe no one loved or wanted her. She had dropped out of school and fallen into prostitution and substance abuse. Anything she could get her hands on, she had tried. Then she met her husband, and, against all odds, they fell in love. He wanted her life and his life to change. Overcome with joy and disbelief that she would have the chance to marry someone she truly loved, she jumped at his proposal. They were married at city hall. That was just days before we met, and now she was in the ICU with what appeared to be a large embolus. Shortness of breath and pain made it hard to talk but she felt optimistic.

We parted that evening, discussing the treatment that would begin after her discharge from the ICU. A cascade of events followed: a pulmonary embolus took her life, a healthy baby was delivered early, and a bereft young father faced the world alone.

The next morning, those of us who had connected with her were shocked, sad, and in disbelief that she had died so quickly. The case holds many learning points and opportunities for the future, but I know for certain there was one thing she told me that she would have wanted everyone to hear: don’t postpone recovery. I like to think that someone else, learning of her death, will recognize that they still have time to turn their lives around, that while recovery was not the way we hoped it would be for her, her commitment to recovery will inspire others.

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