2025

Spirit Lake
Michael Bian

STETHOS™

Medical Humanities Journal of CCLCM

Cleveland Clinic Lerner College of Medicine
of Case Western Reserve University

STETHOS
Medical Humanities Journal of CCLCM
2025

Inside Cover Photo

Aurora Borealis in Cleveland, Moises Auron, MD

A privilege to witness this wonder of nature from Beachwood, Ohio, in the fall of 2024.

Front Cover

Spirit Lake, Michael Bian

The summer before starting medical school, I embarked on a cross-country bike trip to document the American cancer experience. After each day of cycling, my 18 incredible teammates and I would be welcomed into a new community of cancer survivors, caregivers and advocates. Strangers would open their homes and churches, share meals with us, and entrust us with their deeply personal cancer journeys. This photo captures the essence of the trip. Everywhere I looked, I found courage where you'd expect exhaustion, hope blooming in unlikely soil, and a shared humanity that cut across every line I once thought divided us. (Picture taken at the border between Iowa and South Dakota)

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DEAN'S INTRODUCTION

I'm delighted to introduce you to *Stethos* 2025, the 15th edition of the medical humanities journal of CCLCM. I had the privilege of previewing *Stethos* before publication—a great escape on a steamy summer night in July. This week we welcomed the Class of 2030 to the CCLCM family. Like many students entering medical school, my initial focus—and likely theirs—was the intimidating responsibility of mastering the skills and medical knowledge essential to become a physician. Yet, with experience, those of us in medicine come to understand that while skills and knowledge are necessary, they aren't sufficient. A crucial ingredient is the humanity we bring to our profession. Processing our experiences through photography, art, prose and poetry helps us understand the human condition, which in turn allows us to genuinely care for our patients.

As I immerse myself in *Stethos* 2025, I feel the calming effect of the artwork featured in this issue. It includes engaging photos from Northeast Ohio, South Dakota and Central Park; a beautiful recreation of a Monet; and a painting of the welcoming eyes of a dog after a long day. In our hurried lives, these examples serve as timely reminders to slow down, be present and observe. The poetry and prose in this issue reveal many themes that capture the essence of medicine: honoring our "first" patients who unselfishly donate their bodies for us to learn anatomy; the importance of active listening and gaining the trust of a teenage patient; the power of observation, whether through formal visits to institutions like the Cleveland Museum of Art or spontaneous moments at the bedside; the simple yet profound impact of touch and eye contact in calming a patient facing death; the powerlessness and trauma felt when death arrives unexpectedly, be it our patients or colleagues; the stigma our words can carry in our daily work, inadvertently harming our patients; and the bonds that persist among classmates 50 years after medical school. All of this and much more awaits you in *Stethos* 2025.

Fifteen years of *Stethos* is a remarkable achievement! The student editors deserve our gratitude for the journal's ongoing success; they have spent countless hours weaving the submitted material into a coherent representation of our shared experiences. As they so insightfully remind us in their introduction, the very word "stethos" embodies three essential qualities: attentive listening, the "ethos" that guides our character, and the vulnerability of sharing our personal reflections with a larger community. These foundational meanings reinforce *Stethos'* original intent and its lasting relevance. I look forward to the continued success and relevance of *Stethos* for many years to come. In the meantime, dig into this year's offerings and enjoy!

Bud Isaacson
Executive Dean
Cleveland Clinic Lerner College of Medicine

EDITORS' INTRODUCTION

Dear Reader,

As we put together this 15th issue of *Stethos*, the medical humanities journal of the Cleveland Clinic Lerner College of Medicine (CCLCM), we would like to reflect on the origins of the journal. *Stethos* was born back in 2011, with the intent of providing a forum for all members of the CCLCM community and beyond to share and learn from each other's reflections in medicine. The word "stethos" was chosen for the title of the journal for three key reasons. First, stethos is the prefix of the word "stethoscope", symbolizing that we must listen intently to our patients and colleagues if we are to glean valuable insights, similar to how we must listen intently when auscultating a patient's chest to detect murmurs. Second, stethos contains within it the Greek word for character known as "ethos", symbolizing our commitment to practicing medicine with integrity and upholding ethical standards. And third, the word stethos itself is a Greek word that refers to "bare chest", symbolizing the vulnerability of those who choose to lay down their defenses and to openly share their personal reflections and creative works with others. Nearly a decade and a half since its inception, we believe that *Stethos* continues to serve as an enriching forum for sharing and learning from each other.

The overarching theme of this year's issue of *Stethos* is "untold." As members of the medical profession, each day we have the opportunity and privilege to learn from untold stories, whether they be from our patients or colleagues. We invite you into this issue of *Stethos* to appreciate and reflect on prose, poetry, photography and artwork by medical students, residents, fellows, attendings, nurse practitioners, chaplains and social workers.

We dedicate this issue of *Stethos* to Dr. J. Harry "Bud" Isaacson, who will be stepping down from his role as Executive Dean of CCLCM at the end of this year. We extend a hearty thanks to Dr. Isaacson for his continued and steadfast support of *Stethos* and the medical humanities during his tenure as Executive Dean over the past seven years, as well as in his many prior roles at CCLCM.

Thank you to all the authors who contributed to this year's issue of *Stethos*. And thank you also to our readers, without whom our work would be in vain. We hope you enjoy all that this issue has to offer.

Sincerely,
The Editors

‘Just’ a Medical Student

Nikita Das

I file in quietly,
another white coat swallowed
by the river of rounding feet.
Peering past the curtain’s edge,
I catch a glimpse of the patient.

Between the shouts in hallways,
between the orders flicked across glowing screens,
between the weight of thirty lives tallied on a
handheld list,
I stand —
invisible, listening.

I am “just” a medical student,
too new to speak,
too small to change the tide—
yet, sometimes,
I am the only one who sees.

The tremor in their voice when they’re unable to say
“I’m scared.”
The pause when they’re unable to admit “*I’m alone*.”
The silent plea stitched into the fold of a crumpled
blanket.

I tuck these moments away,
carry them from room to room,
a quiet memory in a world racing on.
And though no one notices,
though my voice remains soft—
I see them.
I will not forget.

First Cut, Forever Life

Thriaksh Rajan

In the stillness of the lab, on this sacred day,
I stood before a silent form, life swept away.
Hands trembling, I grasped the scalpel’s cold edge,
And a tide of emotions washed over the ledge—
Curiosity, reverence, an ache in my chest,
A humbling dance with life laid to rest.

This body was a story, a soul’s fleeting home,
A vessel of dreams, now emptied, alone.
Yet within its silence, a lesson unfolds,
Of cycles and journeys, as Hinduism holds—
The atman is boundless, unbroken by time,
Traversing through lifetimes, divine, sublime.

As I carved through flesh, seeking knowledge within,
I pondered samsara, our endless kin—
This cycle of birth, of death, and rebirth,
Of souls roaming freely, detached from the earth.
Where does that spirit, once housed here, reside?
Has it found new form, or in peace does it bide ?

First cut, but forever life.

With each careful line,
I felt a legacy stirring, no longer confined.
The life given here flows into my own,
A pulse of wisdom, through tissue and bone.
In every patient I’ll one day care for,
This person lives on, forevermore.

This act, a communion of science and soul,
Of seeking, of healing, of making whole.
For in Hindu thought, there’s grace in this gift—
A body in death, yet its purpose to lift.
In silence it teaches, each muscle and vein,
A map for the healer to soothe human pain.

Dharma and seva, alive in this space,
A shared act of giving, a deep act of grace.
I felt gratitude bloom, as vast as the sky—
To the soul that once lived, now helping us try
To understand life's mysteries, dark and bright,
To bridge this chasm with wisdom's light.

Om Shanti, I whispered, in thanks, in awe,
For this path I am on, in wonder, in draw.
To honor this soul, I offer my vow—
To heal with compassion, to serve, and to bow.
For life is but passing, like waves on the shore,
And love is the journey, forevermore.

I Forgot to Ask

Tomasz Tabernacki

I forgot to ask
if you were decent when we unzipped the bag.
I forgot to ask
if you were ready, before knife met waxy skin.
I forgot to ask
if the way we'd laid your limbs was comfortable.
I forgot to ask
if you were in any pain.
We traced the sinews that you used
to put yourself on tiptoes
to watch your mother humming in the kitchen.
We felt the breath
that was left inside your lungs
after you told her that you loved her.
We gasped at the sight
of the cancer that stabbed your side
and made her cry in the driveway outside your house.
We cut open the hand
that she cradled as you died.
The parts of you we knew so well
did not cross your mind when you ran through summer grass,
or wrapped yourself in sunshine on your grandmother's lanai.
We knew the body that you left us when you died,
But forgot to ask how you had lived.

New Beginnings

Anika Sonig, CCLCM Class of 2029

The evening before matriculating to medical school, our class (CCLCM 2029) met for the first time at the Solstice Steps in Lakewood. Around us were families on picnic blankets, friends reuniting, and runners near the shore—each unaware of what our gathering signified to us. As the sun dipped below the horizon, we bonded over pizza and looked forward to the beginning of our new adventure together.

Feelings at the Anatomy Lab

Abigail Berk

My mom was my hero. She spent her life dedicated to helping others, no matter what: my brother and I, her patients as a pediatric nurse at MetroHealth, her students as a nurse instructor, the community theater volunteers as the volunteer coordinator, and the list goes on and on. When she was diagnosed with breast cancer that eventually metastasized everywhere, she figured that the best way to continue helping people was to donate her body. She donated her body to Case Western Reserve University. Back then, I knew that I wanted to go to medical school. My mom inspired me to join the healthcare field, and I wanted to make her proud. Who would have thought that over eight years later, I would be standing in the same cadaver lab where my mom's body helped other students learn before me.

Staring at the bag that contained my first patient, I was overcome with a rush of different emotions. I knew my mom would be proud of me for getting to this point, but I was also apprehensive because I didn't want to disappoint her. I was nervous that my patient would remind me of her. I was anxious that others might not treat the patient's body with the respect that it deserved. I was thankful to our patient for making the same decision my mom made, to help others learn. I was curious who they might have been, and what led them to this point. I was filled with grief, both for my mom and for this patient. But I also felt a sense of peace knowing that I was helping fulfill this patient's final wish. I was also confident because I was the only one in my group that had been around cadavers before, as I had done anatomy lab as an undergraduate. So my hands were the ones to unzip the bag for the first time. My hands were the ones to pick up a scalpel for the first time. My hands were the ones to make the first cut.

Her Guiding Light

Cyrus Eghtedari

You must know life to see decay
As you bear your quiet days
And at your end came nature's night
Yet night proves softer in hindsight

'Cause with your light you show the way
In the temple you display
May I study where you now lie
Beneath the curse of my student eyes

And I won't ask the price you paid
While I use my sharpened blade
With trembling hands and heart so fast
I reveal your labyrinth at last

In muscles, veins, and bones laid bare
Lie lessons that are beyond compare
Your heart that once did beat with pride
Now rests outside in formaldehyde

But before the guiding light you gave
I laid in my shadowed cave
With tameless ghosts filling my head
That whispered stoic thoughts of the now dead

And now I lie, and I look up
Praying for those who are out of luck
Within these bodies, we still live
And still our spirits choose to outlive

Upon teaching your last lesson
And after the procession
I'll go into the gentle night
And study under your guiding light

Violet

Ian Brower

Sitting in a sea of blue, green
Boats borne aloft by false bravado
I wonder if you're watching me hesitate
Are you also realizing how much I don't know?

By the work, I am marked
As I learn, I forget
I go home, and it smells like your home
No way to wash my hands of it

Education comes at a cost
Students think they know what price they'd pay
How far would they go to teach?
Did you ever picture the day?

The faces of students?
As they looked straight through you?
Etched into memory, you live
Endless waves of violet, red, and blue

Every heart, every lung
Every hand, every leg
In some small part, they're yours
The debt can never be repaid.

Pier Reviewed

Michael Bian

Cleveland, Ohio
Sunset 10/10
Hike 9/10
Wildlife 20/10
Legs 1/2
Pier Approved

Just a Moment of Rest

Bailey Perczak

The tiny stereo speaker let out a soft blare, one that I'm relatively certain matched the consistent din of the pacer tests we used to take in middle school P.E. classes. There was a collective, muted rustle of disposable scrubs and sneakers on the rubber flooring of the cadaver lab as everyone hesitantly shuffled the two-foot trek to their next station. For me, Station 46: Rest. The roaring cascade of my hurried thought process died down as I departed from the prior quiz station, and a void-like silence began to blanket my mind as my eyes flitted across the room. Clipboards in hand, each of us stood individually in front of a different cadaver body, eyes boring holes into veins that held tiny pins topped with yellow suns, cavities that were threaded by bright blue pipe cleaners, and structures tied off by somberly contrasting silver specimen tags. You could see the concentration in the slight frown between someone's eyes, or the cocky declaration of unquestioned success in another's bored gaze around the room. My brain continued to hum with thoughts about a question I had hesitantly answered three stations back: *proximal attachments... proximal attachments...* I was definitely missing one.

The one minute and eighteen seconds continued to tick by as I turned to face the other wall. My eyes abruptly caught on something at the table two stations ahead: a Band-Aid, wrapped around the second toe of the foot that extended out from the base of the bench. The structure of focus at that station was out of sight, higher up along the leg. But consequently, the lower leg was laid out, and attached to it was, so casually fixed, a Band-Aid. These cadavers were humans—we knew that. These bodies laid out here on each cold metal bench had been people, just like you or me, or our neighbors, librarians, and grandparents—we knew that. But amidst the jumble of lecture, the assigned hours of dissection work, the days of fervent studying to pass exams so we could continue along our paths to become doctors for the living, and amidst the emanating fog of formaldehyde and stiff, markedly unhuman-like flesh, it also at times became easy to distance ourselves from that fact.

The Band-Aid that stared back at me, however, yanked me right back into that reality. It meant that this woman had at some point gone to the grocery store to get a box of Band-Aids, which likely then sat in her family's hall closet in the house just like it would in anyone else's house. She must have stubbed her toe, or gotten a blister from walking too far in rigid shoes, and had gingerly wrapped the bandage around it. A Band-Aid meant a small injury, symbolizing a tiny inconvenience in normal life that was otherwise fine enough to not allow something as little as a minute toe blister to require treatment. Band-Aids only stay on for so long, and this one wasn't contorted or strained—it looked like she could have secured it on only days before. And now she was here. Laid out on a cadaver bench, skin pale and stiff, her unmoving, unfeeling, unseeing face covered by a sheet of nylon, as a student concentratedly eyed her flayed thigh muscles, the student's mind surely focused on nothing other than their battle for the class grade.

It could be any of us: smoothing a Band-Aid across the back of a blistered heel after a night out, wrapping one haphazardly around a finger after a frantic study session interrupted by a papercut, or popping one on after spending too much time running around with friends at the beach, without ever knowing that we, along with that Band-Aid, could end up lying here, just like this woman in front of me. Emotions swarmed my mind: of humanity, sorrow, and fear, as well as gratitude and grief. Of what it means to be here—as a student, a future physician, and a human.

The soft blare of the timer went off again, and my gaze snapped back into focus. That was my cue to move along, to leave my thoughts at the rest station and continue the exam set before me, as we were all expected to do. Up next: Station 47.

Hearing the Untold Story: Human Connection at the Heart of Medicine

Nandan Kodur, CCLCM Class of 2026

During my clerkship year of medical school, I was reminded over and over again about the power of active listening and human connection in medicine. I had a wide variety of patient encounters, but few stand out to me more than the interactions I had with a teenage girl named Amelia, who had been hospitalized for attempted suicide.

I first met Amelia the morning after she was transferred from the intensive care unit to the general pediatrics floor. Prior to meeting her, I read through her medical chart, which described her as a 17-year-old female with a past medical history of postpartum depression who had overdosed on acetaminophen in a suicide attempt, which had resulted in acute liver failure. I then discussed her case with the senior resident and made my way to her room. Standing outside her door, I paused as my mind began to give way to inner chatter. I knew from discussing her case with the senior resident that she had thus far refused to speak to anyone—that she refused to answer questions and was insistent on leaving the hospital immediately. *What makes me think I am going to fare better than the rest of the team?* I thought to myself. After all, this was my first time speaking with a patient who had attempted suicide. I began to doubt whether I was capable of making a difference. Perhaps more important, I was worried about saying something that might worsen the situation—about unintentionally uttering a word or phrase that could be emotionally triggering for Amelia. I needed to approach this conversation with the utmost sensitivity, I realized. So I gathered my thoughts, took a deep breath to compose myself, and entered the room.

My first impression of Amelia was that she seemed reserved and withdrawn. As I approached her bedside, I noticed she had a sitter present who was monitoring her around the clock as part of routine suicide precautions. I introduced myself to Amelia and asked if there was anything I could do to make her feel more comfortable. She looked at me suspiciously for a couple of seconds and then asked for a cup of water, which I fetched for her before beginning our conversation. Initially, I asked her some basic questions to get to know her better as a person. How would she like to be addressed? What is something I should know about her? Is there someone in her life who might want daily updates on her status?

Through our conversation, it quickly became clear that her mind was preoccupied with getting back to her newborn son. Naturally, I asked to hear more about her son, in response to which her face brightened and she began to share more. As she showed me some adorable and goofy pictures of her son, soon we were both smiling and laughing—it felt like I was connecting with Amelia and gaining her trust. At that point, I finally dived into the interview, starting with the question, "What happened in your life that brought you to this point?" I then listened for close to half an hour as Amelia recounted her story. She described the interpersonal challenges she was experiencing with her partner and family. She described the stressors of being a new mom. And she described how the combination of these factors had caused her to become overwhelmed and despondent about her current state and the future, which prompted her to attempt suicide.

I thanked Amelia for sharing her story with me, and then asked, "What do you think might give you purpose and meaning to continue living?" Upon reflecting for a few seconds, she responded by stating that her son was her primary source of meaning—that she wanted to continue living so she could be a mother for him. She then pivoted and asked me when she might be able to leave the hospital so she could finally see her son again. In response, I reminded her

Hearing the Untold Story cont'd

that our treatment plan entailed therapy in inpatient psychiatry for at least a few weeks, a plan that she had vehemently resisted when she had first learned of it in the intensive care unit. And while she still met this idea with resistance, she told me she would give it some thought and that she might be open to a conversation the following day. On that note, I ended the interview for the day.

The next morning when I entered Amelia's room, I found her up and eating breakfast with a pleasant and welcoming demeanor. As I took a seat at her bedside, we bantered a bit, which got her to smile and chuckle. I then proceeded to ask her the standard daily interview questions, after which I again broached the subject of inpatient psychiatry. In contrast with the day before, this time she seemed more relaxed and receptive. I explained to her briefly what inpatient psychiatry entailed and how it would benefit her. And while she still had doubts and hesitations, she listened to me intently and asked relevant questions. For how long would she have to remain in the unit? What therapy would she undergo? Would her son be able to visit her? After a few minutes of back-and-forth conversation, it eventually dawned on her that she needed extra help, so she warmed up to the idea of being admitted to inpatient psychiatry. And while our treatment plan would likely have remained the same regardless of Amelia's response, I think it gave both Amelia and the entire medical team a sense of comfort to know that she was no longer resisting this extra care but rather actively accepting it—that she was willing to accept help.

As I concluded the interview, I thanked Amelia for trusting me and the rest of the medical team, and she in turn thanked me for listening to her story and hearing out her concerns. And when I mentioned to Amelia that this would be my last time seeing her since I would be switching rotations the following week, she turned to the rest of the medical team who had trickled in during our conversation and joked, "I wouldn't fire him if I were you—he's a keeper."

As I reflect on this patient encounter, I think about how it might have played out differently had I not taken the time to get to know Amelia as a person and to listen to her story before discussing her treatment plan. Sure, I had read about Amelia in the medical chart and discussed her case with the senior resident before seeing her in person. But to truly understand even a bit of what she was going through, I had to hear her story in her own words. Not only did this give me a better understanding of her situation, but just as important it conveyed to her that I and the rest of the medical team cared about her as a person, which in turn fostered trust and made her agreeable to therapy. And while this certainly did not fully resolve all of Amelia's medical issues and life stressors, hopefully it got her on the path to get the treatment and support she needed. This patient encounter serves as a reminder that sometimes it's not the blockbuster medication, expensive laboratory test, or fancy gadget that helps patients, but rather it's the lending ear, healing touch, or gentle words of reassurance. And while medicine will certainly be transformed over the next several decades owing to advances in technology and artificial intelligence, I believe that patients will always have a desire for human connection and understanding—a desire to share their untold story.

Disclaimer: Certain details have been altered throughout this narrative to maintain patient anonymity, yet the essence of the patient interaction has been preserved.

Rounded Flower Bed

Mia Carleton, CCLCM Class of 2029

This is a recreation of “Rounded Flower Bed” by Claude Monet (1876). I really enjoy the loose brushstrokes and bright colors that defined the Impressionist movement. I think that creating art, particularly loose, impressionist-style art, can be very therapeutic as a medical student where our focus is often more academic and analytical.

Rotation

Aishwarya Gautam

Third year of medical school—
A year of revolving doors,
Rotating so fast
It leaves you dizzy, dazed, disoriented.
Dark mornings cut with fluorescence.
Indecipherable acronyms, turns down wrong hallways,
Forgotten names and room numbers.
The not knowing anything of it all.

A roulette of personalities,
First—and only—impressions.
Unending questions and constant scrutiny.

Countless bodies listened to.
The frenetic beating of a newborn's chest,
The joy of a first murmur that presents itself to you,
Unfolding to your grateful ears.

New lives, and lives lost.
Kind people, impatient people, devastated people.
Accidents and their aftermaths—
Drunk drivers, and those they leave behind.

And now, nearly a full rotation.
A career, really, of rotations.
Of unending questions
And daily gifts,
Bestowed on a lucky few.

I Wish

Priya Raju

I wish I never met you.

I wish I never let your sly jokes make me laugh,
I never learned about your unjustified love for painting,
I never heard about, and experienced, your life's story.

I wish I never played tag with your eight-year-old daughter,
Held your college graduation pictures in my hands,
Or discovered your savings jar,
When I first visited your home
To place your IV.

I wish I never saw your CT scan,
Speckled with a storm of white radiopaque blotches,
An innocent representation of the sinister to come.

I wish that three short months ago,
You did not enter my office
With a polite smile on your face,
But tears glistening in your eyes.

I wish I never saw your hope,
your grief,
your denial,
and your rage,
become acceptance

No,
I wish I never met you.

Because that would mean
You were okay.

The Art of Listening

Marcellus Wiggins

One of the most memorable learning experiences I was fortunate enough to be a part of in my medical training was when our class journeyed to the esteemed Cleveland Museum of Art for an exercise in listening. On the surface, it seems antithetical to immerse oneself in visual art to train the skill of listening, but I found the outing to be deeply informative.

The focus of this excursion was to take the tools necessary for experiencing art and learn how to apply them to listening to others. We were assigned four pieces to mull over, and I was the group leader for this journey. My group and I sat in front of world-renowned pieces, such as "La Vie," a harrowing piece from Picasso's Blue Period, and "Water Lilies," one of Monet's works that draws you in with its ethereal familiarity. I worried, as the odd mind out who studied the humanities as an undergraduate among the rugged scientific minds that commonly find their way to medicine, that my group would find this journey a waste of time, so I prepared extensively to engage my team in this exercise.

Our assignment was to first look at the pieces, formulate our initial impressions, and then look deeply and try to arouse our deeper reactions, attempting to place a name on these reactions through whatever words we could find. Finally, we were to add in the context in which the piece was created and see how that changed our understanding of the piece and the original author. Each group was assigned three pieces to study, but being the veritable art-snob-in-training that I am, I took my group on a detour to one of my favorite pieces in the CMA, "Alabama," by Norman Lewis, a classic piece of Abstract Expressionism. This piece, on its surface, is black canvas stained by seemingly random strokes of white that elicited an exquisite feeling of disquiet when it had first caught my eye. Initially, my group did not know what to make of it, but I could sense they were also experiencing the same internal unrest I had at first glance. As they looked more deeply into it, one of my group members asked a question that filled me with joy: "What is this painting trying to say?" At this point, I gave them the context of this work. Norman Lewis was trying to depict the ceaseless fear under which he, and many others, had lived during the times of Jim Crow. "Alabama" evokes the imagery of white flames disrupting a placid, black backdrop to illustrate the effect that the mere existence of hateful groups like the KKK had on his mind. A raging fire that can never be fully doused.

Listening is not only a core tenet of the profession of medicine, but the cornerstone on which humanity has been built. It is impossible to perfectly share a thought, emotion or experience with another person, but language and the arts are our best attempts at doing so. As future physicians, it will be our job and our pleasure to receive whatever our patient has to share with us, and to make sense of what has been shared, to work with that patient to find a path forward that works for them. One of the core lessons that I gathered from this experience is that listening cannot be done in a strictly literal sense, and how one receives is just as important as how one shares. That is to say, the personal context of the listener, the emotional reaction of the receiver, and the intent of the listener work together with the speaker and her own context and emotion to ensure the most effective dialogue.

In medicine, it can be tempting to simply refer to what the textbooks say or to formulaically speak in an almost scripted fashion to ensure as few mistakes are made as possible. Ask all these questions in this specific order, run these tests, start on these medications empirically because that's what the data tells us will work the most often. Yet, the patient is their own person, with their own system of values, motives and emotions, their own idiosyncrasies, quirks and features. When I was rotating through the emergency department, a young man presented

The Art of Listening cont'd

with an acute sickle cell crisis, and when I asked him what his usual pain regimen was, he told me he preferred not to say it out loud. At first, this seemed odd. To me, saying names of medications is a trivial matter, but for him, as he told me, he desperately did not want to be seen as drug seeking or be defined by his use of narcotics, and this small thing was how he separated himself from that fate. So, while treating him and dispensing his medications, I made an effort not to state the name of his medications, when possible, and shared with his care team his preference in the matter. While objectively this gesture is small, and from an outside perspective may seem unnecessary, based on what I gathered from *listening* to what deeper truths his statement shared, I felt that this was the best way to treat him as a person rather than merely treating his disease and its symptoms.

So much can be learned from what a person says to you. When someone shares with you their story, context and emotions, he is letting you into the most vulnerable places of his mind. Physicians are fortunate beyond belief to be in this trusted position, and as such, I take it very seriously to tread through this place with the utmost caution and curiosity. If a physician takes everything at face value, she risks missing the most important details that lie just beyond the surface. Another time, while rotating through a psychiatric consult service, I met with someone who was suffering from severe anxiety due to her extended stay in the intensive care unit. Unfortunately, since she recently had a tracheotomy, she was nonverbal, but after hours of talking to her, she told me that a lot of the anxiety came from two places. The first, not being able to communicate with people the way she had for the entirety of her life up until that point, and the second, not being able to see her dog from back home, which she missed with a fervor. So, despite my medical knowledge not being at a level that could be helpful for her care, I did recommend that animal therapy see her, as well as request that her daughter bring in her reading glasses so she would be able to more easily read and write to communicate with her care team and family. While these small interventions did nothing to help cure her acute respiratory distress syndrome, they did help make her time in the intensive care unit more enjoyable, and I still remember how wide the smile on her face stretched when I shared this plan with her.

As a medical student, I am still so new to the art of listening. I am still learning how to listen and how to listen deeply, but I am extremely appreciative that I am able to be trained in this skill. Further, I am so honored that I am able to serve in this position and to listen to those who are trying with all their might to share their thoughts, emotions and concerns. When I reflect on these moments, I begin to anxiously await all the new people whose stories I will be fortunate enough to hear, and I hope that, in those moments, I will always remember the importance of the art of listening, something that is so core to the foundation of medicine.

Connection

Madison Rose-Malkamaki, DO

"You need to look at me. You must look at me. Listen. Listen to my voice."

"Honey?" My husband said softly as I whimpered in the early hours of the morning. Another panic attack was looming. The type when your mind ravages your heart and leaves you breathless, with an utter sense of doom, and an encapsulating fear that ties you in knots. "Listen to my voice. Look at me," he said. That night my husband held me. I attempted to be intent on listening to his heartbeat, and feeling his arms around me, as I finally drifted off to sleep.

Even now, my mind takes me back to the starched white coats clashed against the solemn walls. "We can't operate," the cardiology fellow said, "I am sorry. We will keep you as comfortable as we can." Our patient nodded stoically. He came to our center for an aneurysm rupture in the hopes of a repair, but his was too severe. Too significant. So, in the very hospital that was supposed to give him a tomorrow, our patient would die that day.

Death and I don't get along. We don't see eye to eye. I find him to be a thief, and a rather unfair one, who takes at the worst times and gives very little back. Death is what gave me my panic attack that night, and so many nights before. So many times, my mind tricks me into thinking the stillness of night will put me into an eternal sleep before dawn. Yet, at my rotations, Death coyly finds me. He seeks me out. I think he knows I can't ignore those whom he inflicts. A piece of my soul lingered behind in my patient's room, knowing that he would be visited by an unwelcome guest during my shift, and I didn't have to wait long.

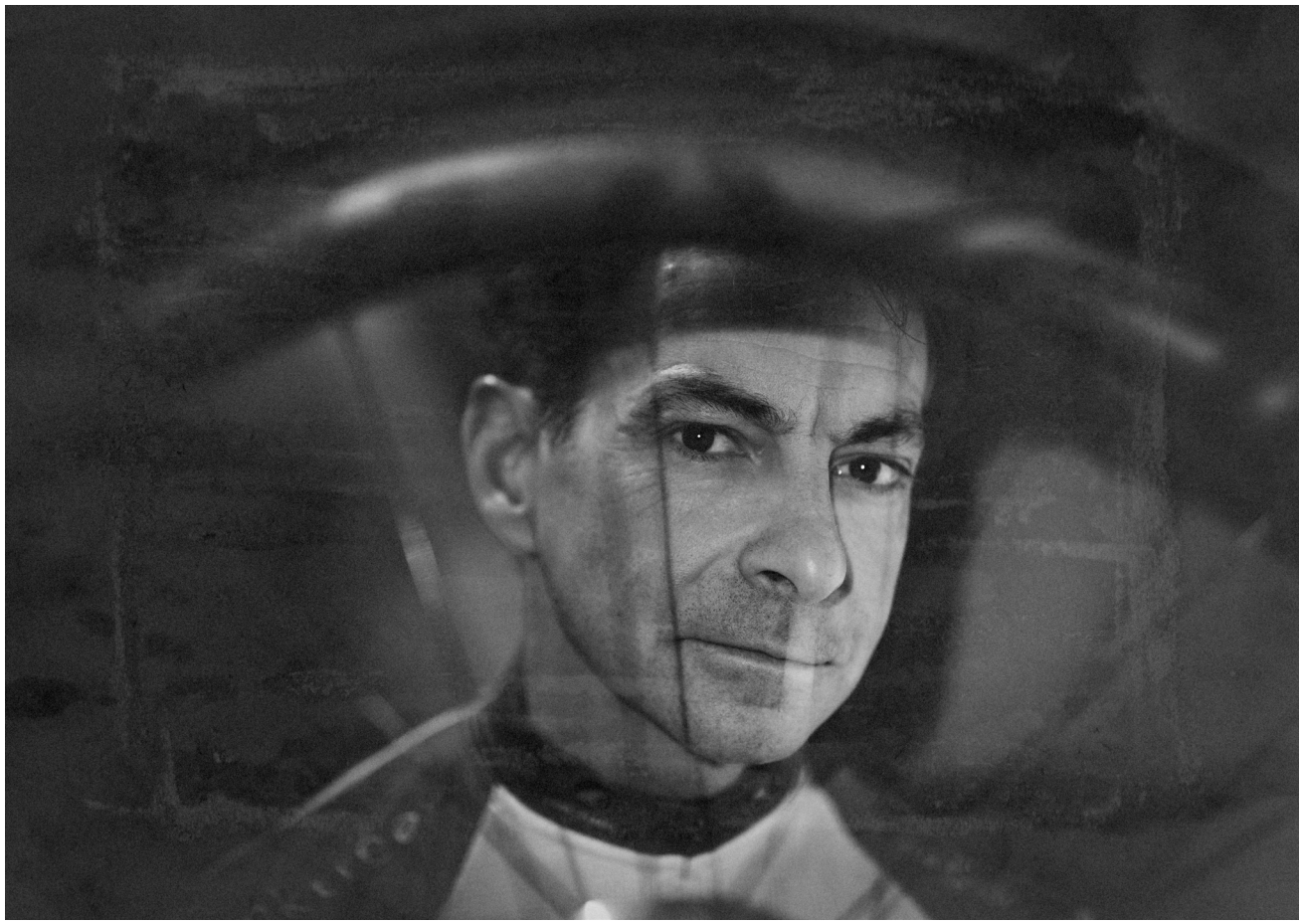
Within hours, the nurse ran around hurriedly when Death started knocking abruptly at our patient's door. The imminent dying process quickly surpassed his pain regimen. My eyes locked with the nurse's eyes as they pleaded for me to stay at his bedside while she ran to retrieve medications. "*No. Not me,*" I thought to myself, pleading with God, "*Oh please*. *Not me. I can't do this*." I was frozen at his door. His eyes were wild with panic and then they met mine. "Help me," he said, "I have to get up. Please help." I inhaled sharply, entering the room and seeing Death at his bedside. My knees hit the cold floor. "Sir," I said briskly. "You need to look at me. You must look at me." Our eyes met. *A point of connection.* I took his hands in mine. I squeezed them hard. "I need you to focus on my voice." *Connection.* "Do you feel me holding your hands?" He nodded. "Let's take some breaths together, okay?" *Synchrony*. "You need to keep looking at me." *Connection.* "Can I sing to you?"

In that moment, I felt Death give us space. Space for shared humanity. Space to exchange a bit of our souls in the little time my patient had left. Time felt as though it had stopped, as if our connection were carrying the weight of the circumstances. When Death returned, he came more gently. He waited for pain medicines to have their effect and waited for rest to ease the patient's mind. The patient's wife arrived, and I stepped out. She was the one who was by his side when he took his last breath that day. She experienced the "peaceful death." I nodded to Death in gratitude. Thankful that peace was able to be felt by the family at the patient's bedside when they arrived.

I ran to find space alone—a bit of solace for myself. I exhaled, and then I mourned and wept as if I had just lost a friend. My shoulders shook as tears cascaded down my face. Years have passed since this encounter, but I carry this patient with me in my heart, reflecting on the experience often. The man who came out of hope and whom I walked hand-in-hand through the process of dying, without knowing how.

Connections cont'd

You see, in medicine we intersect with people at the most vulnerable points in their lives. And as healthcare professionals we get to hide under the guise that this is simply our jobs. It is what we must do. But we, too, are sharing our vulnerability with them. We impart a bit of our spirit, and they reveal a bit of theirs. A complex mix of humanity that can be muddled, yet lovely. So that even in the instance of death, there can be life.



Mike Kattan, 1965–2024

Timothy Gilligan, MD

Dr. Kattan was head of Quantitative Health Sciences at Cleveland Clinic until he passed away in August 2024.

Like Holding Sand

Will Patterson, MD, MPH, CCLCM Class of 2025

From a shell, I learned the ocean's lie—
that tranquil rush was only blood.
Always mine, restless beneath
the quiet
I pretend to hold.

I carry that quiet lie
bedside to bedside.
Press cold metal to warm skin,
secretly hoping
tides might reverse—
might return what they've erased.

Today, I place my stethoscope
like a shell on a still chest,
listening for oceans, hearing only
whispers
where waves once sang.

I reached for his hand
And felt only sand—
grains spilling
no matter how tightly
I hold the shore.

In the deafening quiet,
the ocean slips away—
his breath thinning to seafoam.
imperceptible, then gone.

My fingertips linger
over still veins,
pulse ebbing like low tide.

Outside, I cup hands to ears,
waiting for sounds
not my own.

Something soft wears away in me,
grain by grain, beat by beat—
the tenderness I once held openly
now slipping out to sea.
I wonder,
how many waves remain
before no shore
is left to greet them.

Knowing What Matters

Seth Meade, MD, MS, CCLCM Class of 2025

(A continuation of my M1 reflection in the article titled "Knowing Something" from the 2021 issue of Stethos)

To my M1 Self,

You are standing in front of your first patient, trying to grasp what it means to *know something*. You've shadowed doctors, volunteered in hospice, and learned the basic structure of a medical interview. But sitting across from a man with terminal lung cancer, you realize you don't *know* what to say—or how to fix this. The white coat feels heavier than you imagined, not a symbol of ability, but of expectation.

But you already know more than you appreciate. You know how to support someone in grief. How to be present. How to recognize pain and listen without rushing to fill silence with false reassurance. Presence, you'll learn, is sometimes more powerful than action.

Fast forward five years, end-of-life conversations won't scare you. They will become woven into the fabric of your day-to-day life. Families will look to you not just for diagnoses, but for guidance and comfort. And one day, you won't just be learning how to navigate these moments—you'll lead them.

These conversations will try to numb you. Some of your colleagues will harden to protect themselves, and at times, you may be tempted to do the same. But you must fight that instinct and remember that the capacity to feel and remain present is not weakness—but strength.

One Mother's Day, you'll stand beside a resident as you tell a family their mother has passed away. You won't be there because you have the right words, but because you've learned how to be steady and kind in impossible moments. And when it ends, they'll thank you. You'll be stunned—wanting so badly to do something for this family, but ultimately you'll have no power, no skill, no knowledge to change the outcome. That's when you'll understand: Sometimes what we offer isn't a fix. It's the willingness to sit with people in their grief and invest emotionally, even when we're powerless to alter what comes next.

And then, there are the moments when there is no time for stillness—when your ability to lead with compassion is tested in real time.

One night, a young girl will be rushed into the trauma bay after being hit by a truck. You'll have to deliver devastating news, explain her prognosis, and guide her family through an emergent surgical decision. Her odds of survival will be slim, and her life would never be the same. You will have seconds to balance honesty with hope, compassion with urgency. And then, you'll have to act.

That same night, three emergent cases will arrive. Despite your best efforts, you'll lose that young girl… but you'll help save another critically injured patient in the OR next door. As one life slips away, another holds on. Through it all, you'll watch the residents lead—not just in the OR, but in how they care for one another. They'll check in, regroup and find the strength to see the next patient.

This is what you'll come to understand about leadership in medicine: It's about shaping a culture—one where the intern who's seen too much loss feels supported, where the team stays grounded in purpose. Even when we can't change the outcome, we can still shape the experience. Compassion isn't lost in urgency, and resilience has room to grow. And when

technical readiness meets emotional presence, uniting a team around our shared responsibility of showing up when it matters most, it's a beautiful sight.

That is the leader you will become—not the one who knows everything, but the one who knows what matters. And you will need your team just as much as they will need you. More than that, you will need your family.

The weight of neurosurgery is too great to carry alone. There will be nights when you question whether you did enough—when the enormity of what you witness makes you wonder how to keep moving forward. In those moments, lean on those who remind you why you chose this path. On the nights you spent at your grandmother's bedside, searching for hope. On the fear you felt by your friend's side after he was shot. On the mentors who walked this road before you—and the family who carried you through it.

And in this network of support, God's greatest gift will be your wife, Gabby. She will know when to give you space and when to pull you back. She'll listen when you have no words, and stand beside you when the weight feels unbearable—not to carry it for you, but to make sure it doesn't crush you. That kind of love, and that kind of partnership, is something to cherish.

You'll come to understand that the best surgeons, the best leaders, the best humans, are the ones who allow themselves to be lifted when they need it. Resilience doesn't grow in isolation—it's built within a community. In the wisdom of mentors, the strength of your team, and the presence of those who remind you that compassion is not a burden to bear alone. You are entering a specialty where knowledge is prized. You'll spend years refining your skills and memorizing every nerve pathway. But the most important thing I can tell you is this:

When you look into the eyes of a family searching for hope, what matters most won't be how much you know—it will be how fully you show up in that moment.

So trust yourself. Keep learning. Keep listening. And most of all, keep showing up—not just with your hands, but with your heart.

Above all, never forget: You are never in this alone.

— Seth Meade, MD, MS

Memoir of a Broken Body

Eno-obong Udoh, CCLCM Class of 2027

After observing the workflow of my inpatient pediatrics team, I felt ready to take on a more independent role. So, when my senior suggested I take on the new patient, Skylar, I responded enthusiastically. I was finishing up my shift for the day and had gotten the opportunity to hear about Skylar from the admitting team. Skylar's case was challenging but interesting, perfect for a medical student who typically had a lighter patient load. As this was my first inpatient rotation, I hoped I would meet my team's expectations.

Later, I spent hours poring over Skylar's electronic medical record at home. Skylar was a teenage patient who first began experiencing monthly fevers after an infection as a toddler. Over the years, she had seen numerous doctors and undergone extensive lab work and imaging, including genetic testing, but had never gotten any answers. Over the past three years, the fevers had become near-daily occurrences, and she had developed diffuse pain in her right leg that made it difficult to walk. I was stunned; I could not imagine what it was like to live with such symptoms for over a decade without relief or a diagnosis.

The next day, I was happy to return to the now-familiar hallways of the pediatric unit. The bright colors and paintings brought cheer to an otherwise sterile environment. My team and I agreed that there was a high suspicion of a rheumatologic disease. Walking into her room, I noticed that she had a cheery face and eyes filled with hope. During our interview, I learned that Skylar had often missed school and had given up activities that she once enjoyed because of her illness. This illness, whatever it was, seemed costly.

On rounds, the team shared that we planned to involve other specialists to weigh in on her case. I ran my extensive differential by the team, some of which we ruled out as more information came in. The attending physician recommended that a somatic disorder should be high on the differential, though we agreed to defer that conversation until we had gathered more data. I briefly entertained this idea but struggled to accept it. A somatic diagnosis went against the clean-cut diagnosis I had envisioned.

Over the next few days, I developed a rapport with Skylar. I eagerly anticipated notes from the consulting team and looked forward to sharing updates with her. I grew drearier with every "unremarkable" lab result and every consult ending in "low suspicion" for a catalog of disorders. It was clear that we were approaching a dead end. Still, we awaited two things: for Skylar to spike a fever during her hospitalization, and for an MRI of her right leg. We shared this plan with Skylar and her mom, who welcomed the update. Their demeanor brimmed with hope and expectation. I could sense that this had been a long journey for them.

As suspected, the MRI returned negative, and Skylar remained afebrile. While I was not present for the initial conversation regarding Skylar's diagnosis, I heard the following day that it had not gone very well, so I was filled with apprehension as I walked into her room to pre-round the next day. "Hi, Skylar. How are you doing?" I asked. "Ok. Just want to get out of here," she responded. A cold tone replaced her usual smile and forthcoming nature. For a moment, I drifted back to our communication skills sessions, where I had practiced with standardized patients on delivering bad news when it was unexpected. However, I couldn't remember learning about how to deliver "no news" when the patient would have preferred a tangible diagnosis to make sense of their illness. I told Skylar I had learned about her conversation with the team yesterday and that I was sorry about the outcome. "When we come back for rounds, we can talk about the next steps to help you feel better," I added, though I could sense that my words were not very convincing.

In the afternoon, we returned to discuss the next steps as promised. The "official" diagnosis for Skylar was a type of non-inflammatory musculoskeletal pain syndrome. The pediatric fellow explained what this diagnosis meant using patient-friendly language. Simply put, the pain circuitry between the brain and the body gets "broken." We emphasized that with the right multidisciplinary team consisting of physical therapy, psychology, and pain medicine, her illness could be very well managed. As I stood listening, I could picture these words floating around the room and losing their intended outcome. My eyes drifted to the corner of the room, and I could see Skylar's mom crying. This cry seemed like it came from pain and love—from the heart of a mother aching for her child. Afterward, we asked Skylar and her mom if they had any questions. "No. You called me crazy," Skylar said sternly. The tension in the room grew exponentially, and I could feel my heart break and my feet lose their steadiness. Somehow, we might have missed the mark while trying to provide comfort.

The attending physician, fellow, and senior resident all took turns providing reassurance to Skylar and her mom. The most important thing I remember from this conversation was hearing the fellow say, "I don't think you're crazy." I could sense how those words helped diffuse some of the tension in the room. I learned that while it can seem more "comfortable" to skirt around these conversations, directly addressing issues raised goes a long way in letting the patient know that their experience is not being invalidated or dismissed. Everyone who spoke to Skylar did so at an equal eye level—whether that was sitting next to the patient's bed or squatting—which helped define an equitable yet supportive environment that is required for a tough conversation. At the end of this conversation, Skylar shared, "No matter what you say, I am always going to feel this way." To this day, I still oscillate between feeling that this was oddly comforting and, at the same time, deeply worrisome.

A few months have passed since my pediatrics rotation, and I am often taken aback by how much Skylar's words reverberate in my ears. When I think of her, I think of the old gentleman in my primary care clinic who had suffered for years from involuntary facial muscle twitches with no clear etiology and the despair that weighed his shoulders. I also think of the young woman in the emergency room sprawled on the floor from chronic debilitating migraines and the agony her face bore. I think of many other patients whose bodies are riddled with question marks and their helplessness, to which I am no stranger. Contrary to my initial thoughts, it is not necessarily having therapies or a precise diagnosis that makes a difference for these patients, but rather how we communicate our limited understanding of their illness. In Skylar's case, I realize that some of the communication mishaps may have originated from the idea that a somatic diagnosis equates to a lack of care plan, which was not the case. As I move forward in my career, I am reminded that even though we cannot always offer a traditional course of care, we must remember to support these patients in whatever way possible.

The Tide

Priya Raju

I watch the waves
as they come and go,
Chasing seashells and hermit crabs
that dare venture
too near the seashore.

I watch the tide
as it rises,
and falls.
As it rises,
and falls.

It rises,
and it falls.
I keep my head pressed to your chest,
my eyes shut tight,
as I follow the tide
of your steady breath.

It falls.
My eyes shoot open,
and my heart drops.
It rises.
I relax.

Not every visit was like this.
Five years ago,
You used to tell me
about my mother—
your daughter—
when she was young.
Three years ago,
You would smile at my stories
as I pushed your wheelchair
through the garden.
And one year ago,
You would gently stroke my hair
as I rested my head in your lap,
despite the tremor in your hands.

Every year,
on this day,
I come to watch the waves.
You had said you wanted to be here,
before the disease took your body.
So this was where
we brought your ashes.

I close my eyes,
and hear the tide,
hear your breath,
as it rises,
and as it falls,
as it rises,
and as it falls.

Over the Fence

Priya Raju

Every Sunday,
We came here.

Lie low amidst the bushes,
Lest our voices scare what we wished to see.

And suddenly,
From nowhere,
A fox would traverse the fields,
Leap over the fence,
And race into the sunset.

You would grab my shoulder,
And urgently whisper my name,
Saying “Look, before it goes!”

And so our friendship started,
From watching wildlife after school,
To attending the same graduate program,
To visiting your family for the holidays.

Your hand found its place in mine,
And we became partners for life.

So, the years went on,
Our hairs began to gray,
And your eyes started to change.

First, they seemed confused,
When I asked you
Where you had placed your watch.
But later, they appeared blank,
When I asked you to recall
Your day’s events,
The school you teach at,
The town we moved to five years ago,
And now,
My name.

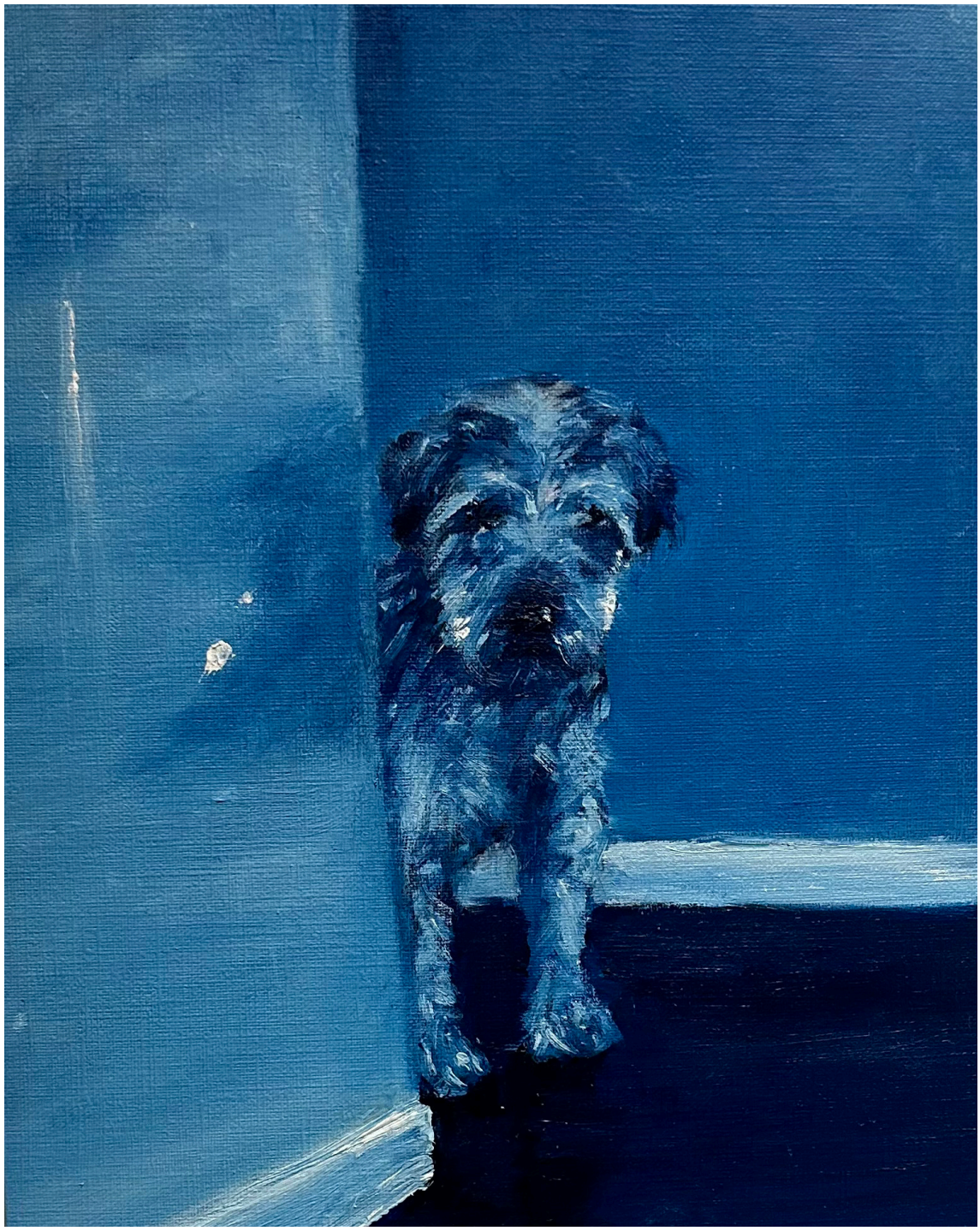
Now,
Every Sunday,
We come here.

Lie low amidst the bushes,
Lest our voices scare what we wish to see.

And every so often,
Suddenly,
From nowhere,
A creature traverses the fields,
Leaps over the fence,
And races into the sunset.

You grab my shoulder,
And with a sense of urgency,
Whisper my name,
Saying “Look, before it goes!”

And I smile,
Take your hand,
And look with you
At the sun falling
Just over the fence.



The Story of a Medical Student's Pet

Pelli Mechnikov

Our pets are our companions—they love us unconditionally. The schedule of a medical student requires loyalty and patience, not just from our human friends, but also from our furry friends.

Galia

Gila Winefeld, CCLCM Class of 2029

Over winter break, I learned that one of my family's friends, who was like a second mom to me growing up, passed away. I processed all the trite regrets that tend to accompany a loved one's passing: I should have called more, should have kept in touch more after she moved away, should have been more grateful and realized what I had while she was alive. I cried for her but also for myself and my embarrassment. I was embarrassed that just a couple of weeks prior, I had told my dad that I didn't feel like calling her—we hadn't talked in a while and I thought it might be awkward after all that time. I guess writing about her is my way of trying to undo that a bit.

My family friend—her name was Galia—was a rare person. I was a serious, timid kid and she was my antidote: quick, bold, honest, opinionated, and with a huge, light heart and bubbling laugh that comes back to me so clearly now. Her sunny reflection still hovers over many of my childhood memories. I remember often being frustrated with people not taking me seriously when I was younger, but Galia always did. We shouldered each of my childish obstacles together. One time I asked her for help with my geometry homework and, although we were probably matched in our level of confusion, her determination far exceeded mine. I watched with some amusement as her pencil darted around the page, furiously retracing circles and tangent lines. She became my trusted companion and confidante. We even shared almost the same name. Fridays, the days she would come over to babysit my younger brother and me, are still *her* day in my mind—the day of hot sidewalk afternoons and rides in her white Corolla.

Years later, as I started high school, Galia moved back to Russia to help take care of her granddaughter who had been born with a complex health condition. We visited once and video chatted here and there, but otherwise fell out of contact. Everyone, naturally, was busy with their own lives.

Galia died, as we found out, from COVID. A recent chemotherapy course had sent a tumor in her spine into remission but left her body vulnerable, and COVID staked its claim. The death was quick and unexpected. I remembered a conversation we'd had in class just a couple weeks prior about how many patients, especially early on in the pandemic, would similarly seem fine for days but were somehow saturating 80% on room air, having to be intubated, and often rapidly declining soon after. No one really understood how or why this happened, but it was the reality.

We often talk about the ethos, the motivation, behind medicine as the opportunity to be with people in their most vulnerable moments, to bear witness to their suffering, to help relieve it when we can, and to offer comfort in the many times we can't. One of the best things medicine can teach us, I think, is to not forget to do the same in our personal lives: to know firsthand from our profession the frailty of health and to let it remind us—constantly, brutally—to turn toward the people we love. The patients who have weighed most heavily on my mind thus far as a medical student are those who are lonely. Those who aren't bring me some peace: an older man who quipped, affectionately, that his wife would pester him about his new medication regimen when he got home, or a woman who had recently suffered a stroke and came in for a follow-up appointment with too many children and in-laws for the small exam room. Galia also lived with her family, and they stayed with her until the end. I know she wasn't alone; I just wish I had been there for her too.

Isotonic

Carmen Jung

wrung dry, I drifted out at sea / the weeks were tidal in the teaching hospital & my mind was following its own rain cycle / days & days submerged / all senses waterlogged / all thoughts, a murky eddy / then the shift is over in a blink of stinging / eyes & I greet a cloudless sky in an unmade state / catch up on what had transpired above, on air, on sleep.

it's a silly, petty form of self-centeredness, but I was never good / at treading water, lacked stamina & sodden / with syrup-leaden limbs, with salt-sullen attitude / thus the surface sank closer instead.

it was during this season that a hurricane tore through the Southeast. / we witness a neighbor's apocalypse over a phone screen / hundreds of lives lost, homes disappeared & among the wreckage / a factory / a great pump of intravenous fluids, dialysate, sterile saline—

& turned out, over half the country's circulation / in the wake of such infarct, the hospital hangs up / flyers to remind us of the fluid shortage / think twice before administering / please conserve the juice & electrolyte drinks for patients / "you know before the shortage, a liter bag of saline cost a patient $90 / sold on the lower end in these parts," a doctor commented, breezily / biting / like a huff of pre-storm static / because let's consider suffering to be / central to the human condition / a natural disaster but also banal / or let's consider it sequelae of industry / a productive necessity / some systemic itch & we cough up a new kind of consumption to manage / expectantly / whatever to stomach the rot.

swallow one's dark bile / exhaust the gall to complain / & take a coin / sublingually for in the myths of antiquity, one still pays / toll even in death to the ferryman. / passenger fare placed under the tongue / whether it is soul or saltwater conveyed between oceanic vein & IV drip.

in the end, it's confetti on the floor. / pack & apply pressure to open wounds / continue to round on your patients / put in orders / encourage oral hydration / hold your breath to the week's end, chest tightening sight blurring pulse pounding on the anvil of the middle ear / & gasp / rinse / repeat: the world can turn / backwards on its axis but go / ahead & carry on.

Was It Too Much?

Ivan Miller, MSN, APRN-BC

I see tears in your eyes, as you look at a body, the man who gave you the color of your eyes, listless, mechanical tubes and hoses providing life's basic necessities. You ask me how long dad's sleep will be. This answer I do not have the privilege of knowing.

The violent jerking, uncoordinated spastic movements revealing myoclonus as evidence of disrupted nerve impulses, with fragmented shortening and lengthening of sarcomeres, while nerve impulses and muscle junctions no longer communicate effectively.

A young soul, crushing him with words bitterly dancing off lips sadly stating, "Dad may never wake up," —this, the possibility is greater than ever waking up! Seeing hope, happiness, and joy squeezed from within a gentle soul. My words albeit spoken softly and inflection gentle, they bring devastation. I sometimes wonder, how did I come to be in a profession of caring, only to constantly bring people dismal news?

I'm reminded of our Heavenly Father Jesus, who has provided provisions of embassy, grief, compassion, and, most importantly, some degree of understanding the human condition. He fills my cup with all things, which allows it to flow into others who need it more.

Young man, I'm sorry, and no words which can be professed will soothe your broken heart. I'm sorry, my team and I are good at resuscitating people and maybe it would have been better if we hadn't pressed on your father's chest, broken his ribs, and made him bleed, and instead let him die in place of trying until the end to resuscitate him. I stare into your father's eyes; he is only a couple years older than me. His eyes knew children like you, and your mother would like to say goodbye, so for this, I tried.

One of my mantras is that there are things worse than death. I will be OK in my family of my Lord Jesus, my loved ones, and myself. But you, young man, have your whole life ahead of you. Short of a miracle, this journey forward will be without your earthly father, and for this you have my condolences, empathy, and sympathy.

With love,
Your father's nurse practitioner

Vitamin Sea

Michael Bian

In learning to support my dog through his blindness, I came to understand that vision is not only the act of seeing, but the deepening of awareness and perceiving what may be hidden or overlooked. The figure may vanish into abstraction, but the presence of being endures. (Picture taken in Charleston, South Carolina)

Chart Notes

Susan Lefelhocz, Mdiv

Pt expressed anxiety around timeline, prognosis.

I don't know how long I have left.
I just want an idea. Some kind of timeline.
Would that be so hard?

Days or weeks or months?

(I wish I could give you an answer)

I didn't think it would go so fast.

She is continuing to process family dynamics and past events.

My siblings and I don't talk anymore. No, I don't wish it was different. I did so much, I gave them whatever they needed, just for them to turn around and treat me like this.

I hate them.

(you keep bringing them up do you–)

I never want to speak to them again.

Pt's priority is time with grandchildren.

I want to get out of here, spend the time I have left with my grandkids.

They're my life.

(your legacy?)

I want them to know they're loved.

We explored grief and emotional needs.

I mean, I thought I'd know when I was dying, I thought it would be different from everything else. But I don't feel like I'm dying. At least I don't think so.

(what does dying feel like?)

From the Patient's Chair

Ravi Dhamija

I sit, I smile, I nod, I speak—
But inside, I am far from meek.
Thoughts that twist and words that bite,
Truths I hide with all my might.

They ask me to share, to open wide,
But how do I show what lives inside?
The meds, the noise, the silent ache—
A weight I carry, hard to fake.

I wear a mask, a fragile shield,
Hiding what won't ever yield.
A silent scream, a mind confined,
Untold stories, left behind.

Then one day, you hear my cry—
Not with ears, but with your eye.
You stay, you see, you understand,
And slowly, I unclench my hand.

Untold no more—I start to speak,
And in your gaze, I'm not so weak.

Unsaid

Baila Elkin, MD

You told me of the worst pain of your life
the search for opiates you could unearth
when agonies exceeded giving birth
and cramping pain came stabbing like a knife

You told me of the dinner you'd prepared
(lasagna was your husband's favorite meal
of how he praised your cooking as "unreal"
and said no fancy restaurant compared)

Your tale complete, I left the room, the bed
but if you heard me, would you be surprised
at how much of your story I excised
when I presented you and all I said

(my goal to be succinct and not long-drawn)
was "biliary colic" and moved on

From Shorthand to Stigma: Medical Jargon and Bias as Subtext in the Medical Record and the Importance of Humanizing Medical Documentation

Maria Mohan, MD

Mr. Canna is a 65-year-old obese Hispanic man with schizoaffective disorder, who is a poor historian, left AMA last admission, has a history of DM, dyslipidemia, CAD and CABG '12, mild cognitive impairment, CVA (non-compliant with Plavix) and residual word-finding difficulty, DBCL treated with RCHOP in 2013, in ED had a Utox + for cocaine and cannabinoids, who is now admitted with a large PE seen on CT.

This would be a typical one-liner written in the medical record or conveyed verbally about our patients. Some members on the team will exchange knowing glances hearing about the patient's naughty behavior such as drug use or leaving AMA. Within a sentence, the clinical team is in a one-up position from this man, who for some reason does not know his medical history, has not maintained a fighting weight, uses illicit drugs, and inexplicably does not take the drugs he ought to be taking. We learn he has a mental illness and may be a flight risk. Despite being a poor historian, the ER has managed to diagnose him with a life-threatening pulmonary embolism.

Remarkably, Mr. Canna does speak fluent English. He fills in a few details about his medical history (his remote splenectomy and his two days of unilateral leg pain) when you encounter him at 9 a.m. The night residents remark that he is much more alert than when they admitted him at 1 a.m. He cracks a few jokes when the team of seven descends upon him. Unbeknownst to him, he had just been reduced—albeit inadvertently and unconsciously—to his colorful habits and deviances from acceptable social norms.

The language we use to describe patients can signal red flags or white smoke signals. The red flags: the patient has somatoform disorder, "bounce back," has TNTC (too numerous to count) drug allergies, multiple prior admissions for DKA. And now, all their problems are hashtags, borrowed from social media. Rather than ranking the problems from most concerning and acute to least, now all the problems are democratized with the #acutedecompensatedheartfailure/afib/ACS, all one jumbled collection of # heart stuff. Emojis to describe the "unfortunate" cases do not seem far away.

Meanwhile, an attending physician has received a veritable information dump of irrelevant and remote rather than recent and relevant history. We get an exhausting and stigmatizing paragraph of obtuse and trendy acronyms. Pneumonia was not always PNA, GH has not signified gross hematuria, and SOB is not what it used to be in common parlance. We also get hit with the punchline, the radiographic diagnosis, in the opening paragraph of the history of the present illness, a potential anchoring bias. Can the real "poor historian" please stand up?

Writing and presentations like this example have become common practice in formal medical training in academic hospitals, at least in the U.S. Notice: no centering chief complaint that would inform why Mr. Canna sought medical attention. Gone are the logical progression of a traditional history of the present illness. The patient's story has been supplanted with a litany of negative traits shuffled into the junk drawer of his medical diagnoses, frequently tossed along with the labs and imaging results. As an attending, getting intel second hand, this may be one of a dozen presentations for the day. That is a lot of mindful objectivity to practice, especially more difficult as one gets closer to lunchtime.

Shorthand to Stigma cont'd

History and physicals, H&Ps, in the purest form, are documents we use to describe, define and illuminate the patient. Yet the language we have instilled into the medical record—the one we utilize to transfer vital information to one another—has a subtext that can introduce judgement and bias. We can better connect with our patients using this document by creating a cohesive human narrative.

Medical training can last a decade. It entails a fair amount of indoctrination. We all quickly absorb the language and lingo to speak and write about our patients to fit in with the group-think and group-speak of medicine. How can we convey our clinical reasoning in an unbiased and humanistic manner?

The acceptance of note-bloat and disorganized wordiness also trades practicality for the convenience of copying and pasting. Meanwhile, the medicalese and partiality in these documents are challenging for everyone to interpret, from medical students to nurses. A nurse with six patients does not have the time to decipher the ten-page note to see what the doctors and other clinicians are thinking. If they could, the daily progress note could also serve another historical function: the nurse could translate the care plan to patients and their families.

While the notes have made documentation *longer*, this does not translate into *better.* The authenticity and integrity in self-generated notes have gone by the wayside vis-à-vis copying and pasting, a ship that has sailed in the past decade. We are less authors than remix artists: each of us sampling the previous notes much like a singer sampling a funk or hip-hop line and incorporating it into their own song.

The medical record cloaks judgment and biases. We have not examined much how these buzzwords and terms of art bias our diagnoses. Doctors are no less subject to bias and flawed judgement than others. We are also trained to utilize heuristics and illness scripts through the type 1, fast-mode thinking described by Nobel laureate Daniel Kahneman in his book *Thinking Fast and Slow*. Clinical thinking utilizes mental shortcuts, algorithms, and heuristics to treat a wide-complex tachycardia using an ACLS protocol, or to generate a differential diagnosis for chest pain. Type 2, slow-mode thinking would be an internist introducing anticoagulation after a bleeding event, or a surgeon pontificating on the complex anatomy they are to encounter in resecting a tumor. Frontloading the patient's story with descriptions of their skin color, weight, addictions and mental health diagnoses may anchor us, and derail us from more medically significant factors at play.

How much impartiality can clinicians reliably have when the introduction to the human you are about to care for is defined by their least desirable history, or by a potentially irrelevant characteristic such as skin color? We can do better to illuminate the patient's story and history, while avoiding judgment and premature closure. We can pay close attention to the insidious flashy vernacular we use, and offer journalistic reporting, rather than an editorial or op-ed piece. This would be a return to the training we learned in the preclinical years of medical school.

Patients are not supposed to be "good" historians. This was not a course in high school or college: to learn to tell your history and to communicate with clinicians the most relevant clinical information in a concise and efficient manner. Patients were not taught that we cannot just skim through the chart and take a quick glance at them and know all that ails them. One could argue that *it would be* a valuable revelation to teach the history-giving skills that people will most certainly need to utilize all their life. Until the time these skills are known by our patients, our work as doctors will be to distill and translate their history with care and coherence.

Here are some of the useful and interesting things that are undisclosed and undefined and could both help us know the human we are privileged to care for, either for a day, several days, or several decades. Mrs. M. Hume is a mother of three young children who are being cared for by their grandmother while Mrs. Hume is hospitalized. Mrs. B. Lane gardens, plays tennis, and has recently retired as a cellist in the Cleveland Orchestra. She has been the caretaker for her brother with Down syndrome for six years. Neighbors are watching her brother while she is hospitalized. As their physician, you may work to expedite everything you can to get them back home more quickly. You now work even more closely with your social worker and case management colleagues, knowing the baseline stress of being hospitalized has been compounded, since their roles as caretakers have been disrupted indefinitely. Mr. S. Anthony has not seen a doctor in 40 years; he saw his mother die while hospitalized when he was 10 years old and vowed never to go back to a hospital. His reluctance to go through procedures is brought to light.

Our professional words, written and spoken, can bring us closer to a position of understanding, one that puts us more in tune with how we can know and attend to our patients. Albert Einstein famously said, “Everything should be made as simple as possible, but not simpler,” a practice we can apply in the written and verbal words we use to convey our patients in narrative form.

Sound of Silence

Aneta Mullins, LSW

The sound of silence. When they don't see you as being a person, with thoughts and feelings; to them you're just another number they will move on from…

Her-STORY

Lora Greene Sowunmi, MD

Stuck!
Too many losses to recall
Future too painful to look forward
Trapped!
Endless moments to reflect on everything:
Meeting you,
Falling in love,
Having our child,
Working and being proud.
A creative professional I once was…..
They called me mother, wife, citizen, and teacher.
So many years of bliss
So many fade to this
Tremors uncontrolled
Dyskinesia, akathisia, akinesia,
Feed tubes and medication pumps,
And newfound names: homeless, unemployed,
malnourished, and depressed.
Unable to walk and burdening you much
Accelerating to the valley,
I lead our descent
I didn't mean you any harm.
Please turn around, my caregiving angel.
No overdose, no cardiac arrest,
All I have is the present, and I need you here.

Stacatto

Gloria Kim, CCLCM Class of 2029

Staccato utterances.

"We don't know what he's trying to say"

One clot and
His name became a string of letters
His feelings, sunlight trapped
His thoughts, waves with no medium to carry them.

When his throat swallowed his words
And reduced his existence to grunts,
His world rapidly collapsing,
We should have built a tunnel
To connect our worlds.

"We don't know what he's trying to say"

But maybe we weren't trying to know.
And in the continental drift
The staccato notes lost sound.

—

This poem was inspired by J, who had Broca's aphasia.

The Land In-Between

Brent Raitz, DMin

Another breath in, another breath out
Is this all going to be worth it?
I can't believe I am in the hospital—AGAIN!
I am tired.

Tired of not being in my own bed.
Tired of feeling like a burden to everyone.
Tired of wondering if today I will be able to hold my food down.
Tired of taking medications. Tired of alarms beeping.

My faith tells me not to be anxious, but that only makes me more anxious.
I am anxious if my spouse will still find me attractive.
I am anxious if my kids will have a healthy mom again.
I am anxious if I am ever going to get out of here to see my new grandchild.

I am trying.
Trying to be a good patient.
Trying to be kind when I am hurting.
Trying not to cry every other minute.

I am grateful.
Grateful for all the people trying to get me through this.
Grateful for my mom and husband calling me daily.
Grateful for all those praying for better days for me.

I am going to make it.
I have to keep telling myself that.
It's what's keeping me focused on the next uncomfortable thing to face.
This pain has to be worth something, right?

And if I don't make it, I will be ok.
I will feel peace that I did my best
That I tried hard for my family
That God has something better waiting for me.

Let Them Help Themselves

Chineme Onwubueke, MD, MPH, CCLCM Class of 2025

"Do you plan to go to school or to start working?" asked Dr. D.

The question was directed toward the 20-year-old patient, whose long eyelashes reached past the black hijab adorning her face. Dr. D sat at the computer, and I stood near the door, careful not to obstruct it and make this family feel trapped. The patient was surrounded by her three younger siblings and her mother, who sat across the room beside the interpreter. Everyone except the father was present.

"I want to go to school," she said through the interpreter.

"I want her to go to work," the mother objected.

"But it's my dream to go to college," her daughter retorted.

"So if you won't help me and the agency won't help me, who will help me?"

The daughter's brow furrowed as a deep frown replaced her calm appearance.

"I was asking because if you want to go to school," began Dr. D, "there are some vaccines you will have to take."

I shifted in my black winter boots as a pang of sadness ran across my chest. A newly resettled refugee family from a Middle Eastern country, they had already endured much. During the years-long transit from their war-torn nation to the U.S.A., the father of the family had succumbed to cancer. Now the mother, newly widowed, was crying under the burden of grief, new responsibilities, and the stresses of resettlement. Complicating matters, an executive order from the federal administration now limited funds to resettlement agencies. The family had made it to the U.S. just in the nick of time before refugee resettlement was paused, but now the funds previously guaranteed to help families resettle within 90 days were lacking.

Every eligible family member needed to work ASAP. But her daughter just wanted to go to school.

"My child goes around turning off the lights at home because she is afraid of spending money on electricity," the mother shared about the youngest daughter, further illustrating their plight.

Though not the point of this conversation, this situation began to convict something in me. Unprovoked, the green WhatsApp icon flashed in my mind as I recalled a controversial conversation in one of those many Nigerian group chats from days prior.

"*Return to your country and change the narratives*," the writer admonished in support of recent deportations from the United States. "*Stop depending on WHO for subsidized drugs…Go and hold your ruling class accountable for rots in health care delivery.*"

Maybe the writer was trying to make a point. Maybe the writer was trying to pick a fight. Regardless, the point, on top of the situation in the room, shot something into my core.

Was I pursuing a career that required people and nations to be dependent? The reason I was on this refugee health elective was because of my interest in public and global health. I dreamed of eventually doing work with global entities that uplifted nations, targeting issues in different low- and middle-income countries. But recent events had me thinking deeper about my motives.

Perhaps I had a lesson to learn from my poor Honda.

Early one Sunday morning, two weeks before this elective, I awkwardly hurried down the stairs with cajón slung over one shoulder, purse over the other, Brussels sprouts on one arm and Bible tucked in my armpit.

I can't be late for worship rehearsal! I screamed within. *I have no good excuse!*

At my car at last, I opened the trunk, stuffed the cajón in, opened the driver's door, and-

Gasp

I stepped back.

Glove compartment: open. Steering column: flayed. Passenger back window: shattered. Key ignition switch: gone.

Well, at least they couldn't steal it. And now I had a great excuse to be late.

For many weeks after, as my family and I waited on insurance, my car sat at the auto repair shop, and I sat on whatever vehicle could get me from point A to point B. For the refugee elective, I was so grateful for Dr. D, who went out of her way to pick me up in the mornings. I was grateful for my roommates, my churchmates, my friends, the RTA, for everyone who offered me a ride or who said "yes" when I asked for one. But the biggest help to me at that point would be restoring what had been lost so that I could live with greater autonomy once again.

Empowerment, an unseen figure whispered in my ears.

Perhaps *that* was what my career motivation was missing. Since I was a little girl, I had been bothered by the disparities created by poverty and wanted to address them through global health work. But how often did it occur to me that the people I wanted to help would love to be in my position to do the same? This girl and her family had their lives upended by war. They were not refugees by choice. Thus, her status didn't mean that all she was looking for was a kind hand to help her family get their basic needs met. That was important of course, in the same way it meant a lot to me to have people give me rides. But just as I wanted my car back, she wanted her life back. For all I knew, sis was trying to become a doctor too.

"Well," Dr. D began, mediating the conflict, "you can go to school and work part-time. I know many patients who do that. In that case, I would recommend you get the vaccines for school."

I nodded in agreement.

It all reminded me that the global efforts that exist to support people in trying times and improve systems are good and necessary. But if and when anything perpetuates dependency, it needs to be investigated. If my career activities inadvertently perpetuate dependency so that I can stay relevant, I need to be investigated. Empowerment is key. For perhaps the greatest way to help people is to let them help themselves. That way, if everything is taken away from them, they have a better chance to still stand.

Amidst the sorrow in the room, a little smile escaped me. This girl had a future she was after, and her refugee status wasn't about to destroy that.

The Other Side

Chineme Onwubueke, MD, MPH, CCLCM Class of 2025

The patient is not their condition
They're more than their disease
Truths that roll off the tongue
With exasperating ease

We remember the beautiful
As we humanize others
They are cooks and doctors
Also mothers, and brothers

But alas, isn't that halfway?
Is all that makes one so tame?
If we humanized them fully,
Would we care for them the same?

.....

You're a single mom of four
Tirelessly working to make ends meet
Little support to help you
Yet you won't accept defeat

But you snap so fast at your youngest
And eye him with disdain
How can I be sure you're not abusive
Inflicting ACEs-causing pain?

You're a refugee from Sudan
Persecution forced you to hide
To live in camps while fearing
Death from drought or genocide

But sir, I see your smirk
The way you eye me from the side
In camp, did you honor refugee women,
Or did you perpetrate with pride?

You are an older man
A long life so full of years
Now bedridden and suffering
With no family here to care

But your daughter's intentional absence,
Though it makes my heart sad,
Leaves me wondering who you were to her
Perhaps a deadbeat dad?

In truth, vulnerability does not equal innocence

.....

Some may call me jaded
But maybe I'm just sage
Wisdom of the heart's condition
Comes with greater age

Or perhaps it comes with an ex-fiancé
Acting as an angel of light
A man who wooed me successfully
With such cunning delight

Saved 3 months before "I do"
I was granted a new pair of glasses
Not as rose-colored as my birth ones
A pair that won't give free passes

With such vision, it isn't hard to see
That I too am not exempt
From the reality of superficial pleasantries
Coating inner dark contempt

How many times have I hoped
That a patient would no-show
So I could drive off and go home
Unwind, and lay low?

Or how often is my focus
To present well during rounds
So that I don't look stupid
Regardless if Patient lives or drowns?

Alas, what to do in a life of hypocrisies and contradictions?

.....

When I entered this profession
When I took that oath
I promised to care for them all
The “good,” the “bad,” the both

To care for one another
Beyond what one has done
We need a higher love that surmounts
What renders compassion undone

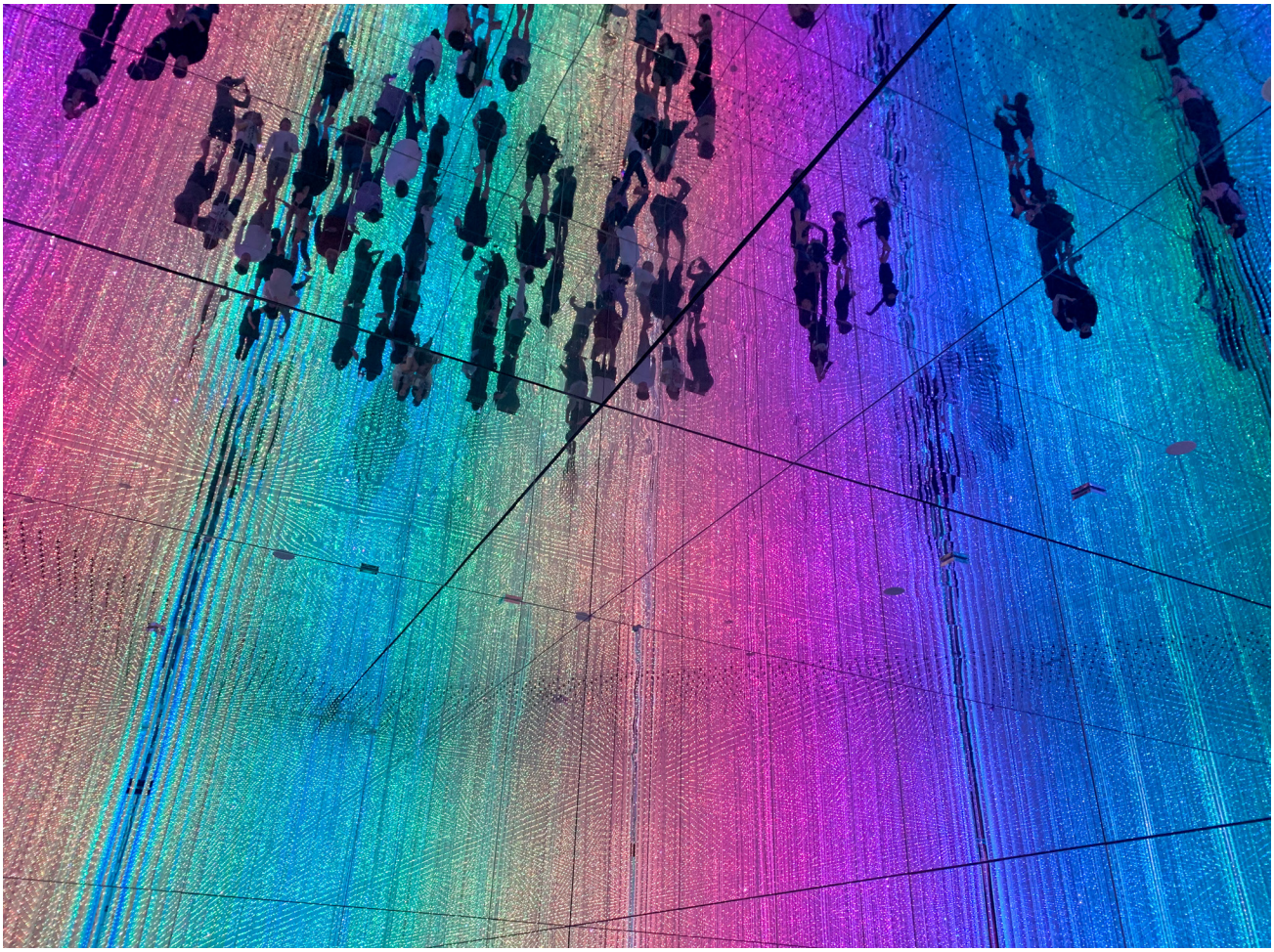
The patient is not their condition
They’re more than their disease
A fully human person
With layered realities

So help me God to remain committed to this calling

Stethoscope

Madison Rose-Malkamäki, DO

I have listened to your beating heart
Ears focused in on rate and rhythm
I have heard a broken heart and the whoosh of turbulent flow
I have heard your child cry with deep wheezes and piercing coughs
But recently, I have heard so much more and so much less
I have heard lung sounds unequal after intubation
Agonal breaths of a soul hanging on to earthy life
I have heard the gurgling of an OG tube balloon
And I have heard silence
I have heard my doctor hold her breath waiting to hear something, anything
But silence.
I have been held in trembling hands filled with adrenaline, anxiety and despair
I have been slung over bed railings so that my doctor could perform CPR
I have been confidently draped over her neck with joy after hearing more beats
And solemnly after hearing none
And then I go back to the other patients for the rest of the day
Listening to the hearts of those who still need care.



Situs Inversus

Michael Bian

Pointillism and mirrors come together to create an infinite light universe. This is not a static artwork, but a living system responsive to presence and shaped by the motion of the viewer. The viewer becomes both subject and medium, a mirror and a movement embodying the fluidity of perception and the instability of meaning. We are not just witnesses to transformation; we are its source. (teamLab, Tokyo, JP)

Gallstones

Timothy Gilligan, MD

Your gall bladder doesn't know any better
The poor thing
Squeezing digestive juices into your bowels
After meals

Filling with bilious liquids
Until the plump tension of its walls
Want to burst:
La petite mort verte

Who hasn't wanted
To squirt into a storm of excrement
To turn the waste of the world brown
To leave his mark?

Stones build up
They block your flow
You have something to say
But the way forward is closed

The urgency builds
Swells
You grip your sides
And swear upon all that is holy

Make this pain stop
Bring me release
Don't let me be consumed
By a fit of colic.

How's It Going?

Anthony Gallo, DO

How's it going? Though I know the hushed truth,
A breath too short, a weary mind too strained,
In halls where duty carves the path of youth,
Where transient joy is lost and wisdom gained—
A fleeting moment, swallowed in the night,
Each patient's plea, an unclear thought in flight.

With hands that tremble 'cross the charts I mark,
The pulse of life and death—each day a race,
Research calls, deadlines loom, a hopeful spark,
Yet still, the steady breath I must embrace.
The papers pile, the journals whisper cold,
A fellowship's hope, as I grow more old.

The attendings' words like swift scalpel cut,
Their expectations pressing, hard to bear,
Each gaze a challenge, each day more a rut,
Yet I must climb, though weary and aware,
That in the quiet hours of endless care,
I lose myself, my spirit worn and bare.

A marriage new, pushing against the storm,
With love still fresh, but time is scarce to share.
Her smile, a solace, but the world transforms—
I long for balance, yet it's never there.
She waits while I in dark workroom remain,
Time slips through, longing to see her again.

My body aches—forgotten meals, no rest,
The gym, an echo, once a place of peace.
My soul, a chorus, sings of love and stress,
Yet, both demand the fullness they release.
How do I stay? How does this heart endure,
When all I seek is simply to be sure?

I wonder, in the stillness of the night,
How's it going? The answer's in the fight.

Obscurity

Anika Sonig, CCLCM Class of 2029

There's something about walking through Central Park on a cold, foggy winter day that reminds me of making a medical diagnosis. Details are obscured, demanding patience, intuition and trust. Yet, just like the lamplights cutting through the fog, there are moments of clarity—a symptom that clicks, or a patient's relief after treatment—that illuminate what was once hidden.

Looking Through the Glass

Niraj Vyas, MD, MBS

It begins with the usual ritual:
Wiping of the lenses to perfection, the click of the bulb
warming to life,
the clack of the glass hitting the stage, the comforting
snap of the lenses in position.
The wonderful concoction of pink and purple hits the eyes.
Panning … panning … panning.

Crystals. Large nuclei. Prominent nucleoli staring back.
Blue mucin filling the gaps.
Mitoses, not a field without them.
Glands? Maybe? If we can call them that.

From whom does this tissue come? Who is this Person? A Red King?
There is no special stain for emotions, no way to see
the anxiety, trust, confidence or humanity,
no images of family between cells.
No reflection, no mirror.
The slide is sterile, free of the contagion
of Life, just like
everything else in this Laboratory.

What will this Person do?
Maybe they'll cry after reading the cryptic text sent out from the Laboratory.
Maybe they'll shout in anger at the Laboratorians, Queens who condemned them to their malady.
Maybe they'll ignore the Laboratorians, not recognizing their existence.
Instead they will lament the lack of natural talk from the Gatekeepers,
White Pawns tasked with deciphering the Laboratory, stuck in the second square.

Silence. Neutrality.
Such is the way when looking through the glass.

24-Hour Shifts for Life

Peter F. Sarnacki Sr., DO

I could have been
a good doctor, but I became
a father instead.

I could have been
a good father, but I became
a doctor instead.

Still—
these 24-hour shifts
what beautiful lives
get to be lived.

Reflections on an Elective in Cognitive Behavioral Therapy

Kathleen Franco, MD

In 2007, I offered to start an elective on cognitive behavioral therapy, primarily intended for second-year medical students, who were preparing for the daunting and important USMLE Step 1 exam, which at that time had a numeric score rather than being pass/fail. Cognitive behavioral therapy involves reflecting on how our thoughts and cognitions influence our feelings. This therapy improves our resilience and enables us to overcome loss, handle challenges, conquer procrastination and gain confidence. While second-year students were the primary intended participants, soon first-year students started to join to get a head start, and within a few years senior students also began to join.

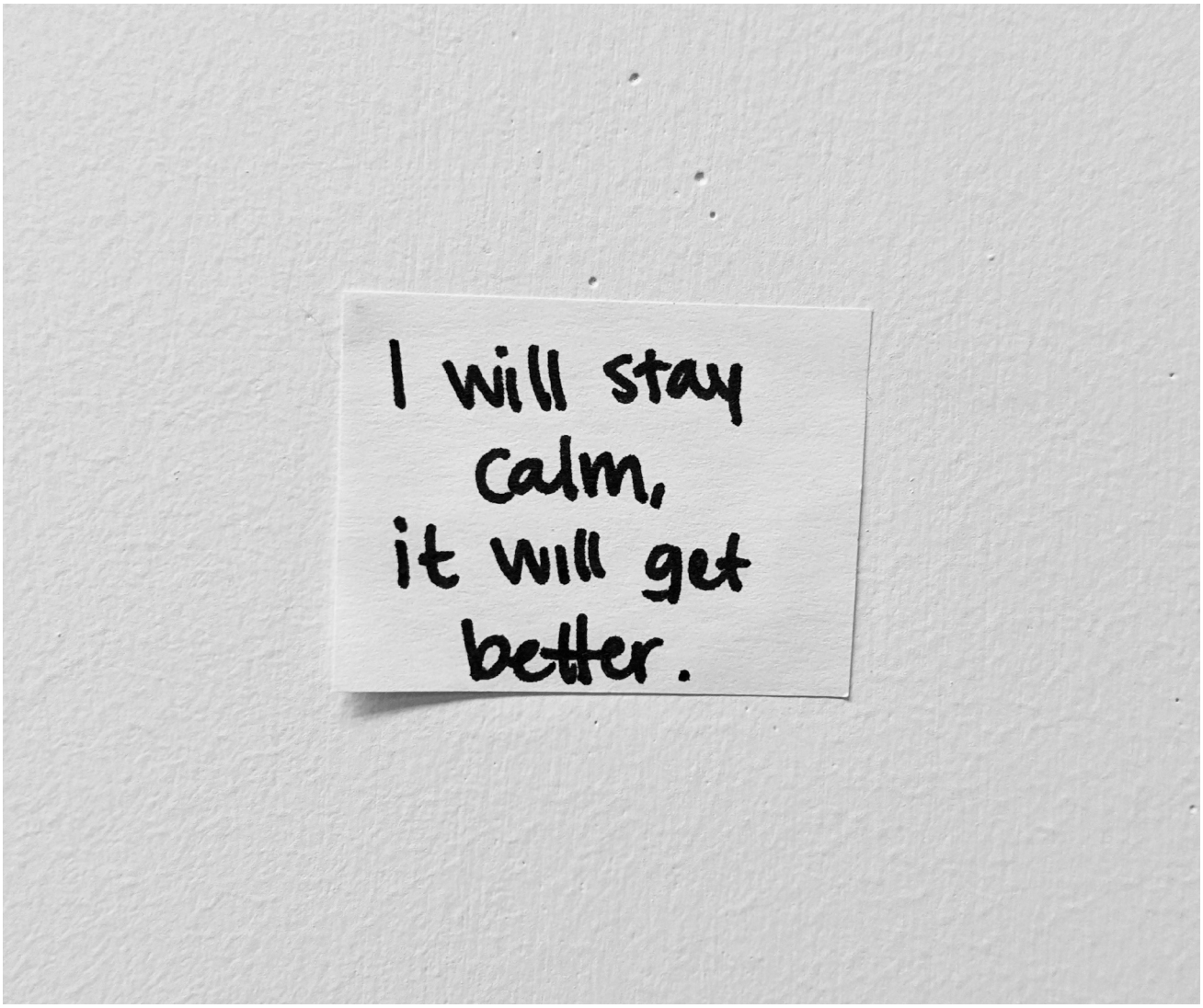
Students have input regarding which topics are most important to them. Some years it's procrastination, while other years it's difficult conversations, with anxiety and depression almost always being relevant. Stress regarding board exams, portfolios, family illness, thesis projects, the residency match, and family or roommate arguments are expected. Such hurdles are expected in both medical school and in life as they persevere and move on to the next steps of their journeys. We explore our values and record how we spend our time to maximize the precious hours in our daily schedule.

After COVID closed on-campus classes in 2020, it was unclear what to do with the elective. Fortunately, Zoom was rising in use, which allowed students to join virtually, whether they were taking a research year at the National Institutes of Health in Bethesda, tuning into class from home in Cleveland, or anywhere else they happened to be. One year, students decided to meet in person at a coffee shop during a school break to encourage a classmate who needed their support. This classmate later told me that this experience meant more to him than almost anything else in medical school.

What has been unusual this year has been the amount of anxiety created by politics. Between dramatic attacks on science and research, and fears for the immigration status of close friends and family, students feel less secure in their plans. Will future pediatricians be able to protect their young patients with vaccinations, or will measles take more lives? The rate of change could hardly be faster.

Every week, we continue to look for ways to continue living our lives with purpose. We refuse to give up on humanity, from random acts of kindness to service and care for others. Students found skills and resilience during the COVID years that got them this far. They now have new tools to examine their thoughts and emotional responses. They know how to analyze and identify over-generalization, discounting the positive, jumping to conclusions, mind reading, and many more unhealthy patterns of thought. Thinking objectively and allowing for positive alternatives, weighing costs and benefits, giving themselves credit for the good they are doing, and learning tools to handle difficult conversations are ways they can help themselves and others.

The way forward will require us to hold on to our deepest values and to not give up on caring for others. We will listen with understanding and look for ways to regain the trust of those who have lost trust. Finding gratitude in corners we did not expect is especially critical. No matter how small it may seem, hold on to that joy. Do not let that be taken away. It will take energy and effort with every encounter. It will require relentless commitment and maintenance of hope. But in the end, it will be worth it.



Aftermath

Eno-obong B. Udoh, CCLCM Class of 2027

In the months following the pandemic, the halls of the housing office grew quiet. The usual bustle of students walking in and out to rent sporting equipment or pick up mail was now a distant memory. While on an early morning shift, I came across this note on the walls enclosing the mailroom. It was the first sign of recovery and of hope—a reminder then, and even now, that difficult moments eventually fade. (Picture taken on February 11, 2022, at Cougar Village, Southern Illinois University Edwardsville)

You Bring You With You

Alicia Castellanos

The yesterdays slink behind,
Like a step that matches your own, an invisible bind.
Hard-won truths, memories that stay,
They forge your course, they light the way.

The Earth tilts beneath, your balance tested,
You don't turn—for only salt awaits—your mind protested.
With each step, you carry the weight,
The knowledge you've gained, the path you create.

When doubt gnaws at your chest,
You trust—
In yourself, in the hands that made you,
In the whisper that flows through time's edges.

You bring you with you,
And in that weight,
There is a will that will not bend.

What I Never Knew How to Say

Nikita Das

How could I ever explain
why I am drawn to this work?
It feels beyond words—
something I only know quietly, inside myself.

Hours into an operation,
when the weight settles into my legs,
and the world narrows to the small circle of light ahead,
I watch an attending, steady and sure,
thread instruments through delicate corridors,
lifting a tumor from where memory lives,
offering, with careful hands,
a little more life, a little more time.

For a long time, I kept it to myself.
I hesitated when people asked,
"What specialty?"
I saw the way they paused, the judgment in their words.
And for a while, their reactions
made me wonder if I should be quieter about it,
if I should want something easier to explain.

But lately, I think — what is there to hide?
The field has its flaws.
I see them.
I walk toward it anyway, not out of certainty,
but out of respect for what it dares to ask of us.
I know there is so much to learn, so much room to do better.
And even knowing that, or maybe because of it,
I feel called to it.

It isn't about believing this path holds more worth than another —
only about believing the work matters.
It's about the quiet understanding
that if a mind needs mending,
if a life hangs somewhere between hope and loss,
then someone must be willing to stand there.
And maybe, I can be that someone.

50 Years Since Graduation

Kathleen Franco, MD

This is the year of my 50th medical school reunion, a chance to see my old classmates. We have recently been in touch with one another about having a final opportunity to share stories of our time together as well as what has happened in our lives during the intervening period. Many of us thought we would never have the opportunity to meet up again before we died. Perhaps some of us were a little afraid of the idea of the reunion, but the more we talked, the more we wanted to see each other.

We were part of the fourth class in a new medical school that graduated students after only three years. Apparently, after cutting down vacations to only a few days, the curriculum could be compressed into three years. In this program, we needed to rely heavily on each other, more than we even understood at the time. Perhaps a little fear came along with being enrolled in a new school with a shortened course, but we ultimately pulled together. If someone was sick, absent, or did not understand the material, it was our job to help them. We were family.

Ten members of our group have left the world—which is a lot, given that we only started with just over 40 members. The first to leave was a wonderful friend whom I sat beside five days a week for two years. He was smart and would often explain complicated concepts even better than the lecturer. And he was also funny, which I was reminded of recently when another one of my former classmates recounted a story. We had a professor who had written an entire book on acid-base physiology, and he believed that the best way to teach us was to go through each and every page of his book saying, “next slide,” “next slide,” “next slide” for his entire hourlong lecture (reflecting on it now, I wonder if all he wanted was for us to buy his book). During these lectures, it seemed like the entire class was completely confused, with a new slide of information appearing every few seconds on the screen while our minds were still trying to process the previous slide. At one point during one of these lectures, my friend jumped up while waving his arms and said, “I can’t take this anymore,” as he walked out of the room. When he did this, the rest of the class suddenly stopped feeling overwhelmed and felt relieved by the humor. This is one of the many stories my former classmates and I have shared with each other as we begin to get into contact and enjoy our wonderful memories.

After graduation, my friend moved to California. While we kept in touch, he unfortunately developed HIV along with AIDS and subsequently passed away. After his death, his sister wrote to me and shared that she was making a panel to honor him as part of the National Memorial AIDS Quilt, and I traveled to see the panel on one of its trips across the country. In the panel is a picture of him with a white coat and a stethoscope, among other things that were important to him in life. The world lost a wonderful physician at the young age of 42.

The other nine classmates who died lived long and fulfilling lives of service. Recently, another classmate and I looked up their obituaries, which revealed that they were compassionate, great listeners, and willing to sacrifice to help others. It made us proud to read about our former classmates and to know that they lived out their values.

We are currently creating a memory book, and one section contains our views on the changes we have observed in medicine. For our class, although the

joys of medicine have far outweighed the negatives, many people have retired early, perhaps owing to the excessive documentation, burdensome regulations, or demanding patient volumes; these are all taking a toll on physicians and other medical professionals.

My classmates and I stand with today's young physicians who have the same caring attitudes and values that we once aspired to—the desire to care for all patients who enter our doors to the best of our abilities. Recently, I talked with a young physician from New York who works in a clinic in which 15% of his patients are undocumented. He is worried, given all the changes that are currently occurring. My husband always says, "The pendulum will ultimately swing back in the other direction." The class of 1975 prays he is right. We believe the pendulum will swing back again, but the question is when, and whether we will be around long enough to see it.

Fire Canvas of Hope and Beauty

Moises Auron, MD

A sunset in downtown Cleveland, Ohio, in December 2024 outside Cleveland Music Hall after the Nutcracker Magical Christmas Ballet.

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