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FROM THE DIRECTOR

Years ago, in my first week as a patient advocate in a NYC hospital, I accompanied a father whose infant son had died, to the hospital morgue. I carried the remains of his newborn. We were silent for the ten-minute walk. As we approached the morgue, the father asked me how such a “nice young woman” could have such a horrible job. He scolded me for the work I was doing, and began revealing intimate details about his life and his enormous rage at the death of his child. When he stopped talking, we entered the morgue and delivered the child’s remains. We parted at the door.

For months I cried when I thought about my inability to talk to the father.

A few decades later and with experience in Medical Humanities, I realized my silence was—by default—the only thing I could have done. I listened. I held the space for the father. I didn’t try to fix what could not be fixed. I now know that what I provided was an important aspect of what healthcare practitioners should be trained to do. And it is what the University of Arizona’s Medical Humanities Program is doing. We are using the literary and visual arts to teach our medical students to listen and provide compassionate care.

In addition to publishing Harmony Magazine, which I know you will enjoy from cover to cover, the Medical Humanities Program continues to grow. Our first year medical students take a class in Narrative Medicine, an aspect of Medical Humanities that sharpens their skills of observation and communication. Students may also take a semester long Medical Humanities enrichment elective, where they explore issues pertinent to medical students. During their medical training, students reflect on, through facilitated writing exercises, a variety of topics related to their current experience as well as to their future concerns in the healthcare field. Some of these writings are included in this magazine.

Older issues of Harmony Magazine are available at the newly created Arts, Wellness and Health Humanities library, a partnership of the Office of Curricular Affairs at the College of Medicine and the University of Arizona Health Sciences Library. As part of this association with University of Arizona Health Sciences, we have also installed a Reflection Room where medical students, faculty, and staff can access a quiet, private room for meditation within the University of Arizona Health Sciences Library.

As I complete my first year as Director, I am sincerely grateful for all the support and guidance provided by the Curricular Affairs staff and faculty, especially Dr. Sean Elliott and Jerie Schulz, and to the medical students who continue to request more from this Program.

Eilen Melamed, MA

Director, Medical Humanities Program
Curricular Affairs Department
University of Arizona College of Medicine
Losing track of time happens so frequently in life. From busy days at work where you just blink and it’s suddenly 5PM, to first dates where you simply laugh and three hours have gone by. I recently lost two weeks in October. I remember helping my grandpa into the car to take him to the hospital one morning and when I looked at the clock again, we were sitting with my grandma in their house in a world where he didn’t exist anymore. My grandpa was the strongest, kindest man; coming over to the United States and raising a family in a country where you don’t know the language is never easy, but he did it. He was my number one supporter from day one when I told him I wanted to be a doctor as a little girl and I know this support will never end as I continue on my career as a physician scientist.

In my first two years of medical school, I learned about mechanism of actions of drugs and the pathophysiology behind diseases. How to perform a physical exam. Where the saphenous, femoral and tibial nerves were. However, nothing could have prepared me for the influx of emotions that I would feel from losing a loved one. I watched him undergo test after test in the emergency room and was with him as he took his last breath; it was like living a nightmare.

I have had time to process since then. Just like how medical students have had time to process their first anatomy lab experience with their cadavers as seen in “Jumping (in)” and “Dear Donor” and with patient experiences as seen in “10:54:45.” Or expressing the emotions that are felt as something good or bad transcends as captured in “The Sense of Something.”

The discipline of medical humanities is not something that students in healthcare are necessarily tested on during exams, but its importance should be underscored. Patients and their loved ones are at some of their most vulnerable times when they need to see healthcare professionals and art and prose are valuable outlets for them to express how they are feeling and understand what is happening. It is an outlet to honor the people in their lives and the experiences they are going through. And for healthcare professionals, it is a way to reflect on the pain, suffering and successes that is seen with all the patients they care for.

The reflections we have compiled in this issue of Harmony are beautiful and raw and it is an absolute privilege that these authors and artists have allowed us to go on their journeys with them. This collection would not be possible without the program directors, Ellen Melamed and Jerie Schulz, my co-editor Natalie deQuillfeldt, and the members of the editorial board (Bianca Kao, Jenna Kay, Marine Khachatryan, Holly Lawry and Tesneem Tamimi). And of course, thank you to you, the reader as it is through your support that the works of our artists and authors can live on.

Always,

Julie Huynh
In February I began the first clerkship of my third year of medical school. It was finally the day I had eagerly anticipated while poring over PowerPoint slides and textbooks. However, if you remember your first day of high school, for example, you may recall being painfully aware of the lowliness of your rank compared to your more seasoned colleagues. I was afraid that I would be a burden to my team of residents, nurses, PAs, and other ancillary staff. Instead, I was struck at how vital we, the medical students are, our ability to influence patient care in a meaningful way, and by the versatility of the role we fulfill.

Having no conflict of interest, many patients feel that we are caring for them because we want to, not out of obligation. Compared to busy residents, we have more time to listen and observe. Even when we aren't contributing to medical treatment, we are able to help in small ways such as finding a pacifier that will soothe a picky infant or walking with post-surgical patients in the hallway. In reading this issue, I hope you will be inspired by the medical student experiences shared in “The Wards,” “Phenomenal Medical Student,” “Broken Heart Syndrome,” and more.

This year, I was awed by the magnitude and extraordinary quality of the submissions to Harmony, particularly the contributions from those experiencing illness in “Resilient” and “Next Year,” patient observers such as the author of “Buddy’s Blues,” and photographers who present to us faces and landscapes from around the world. Unfortunately, more and more healthcare workers are bearing witness to the consequences of socioeconomic and political strife, as evidenced by pieces such as “An Emergency,” “They Prepare, They Journey, Some Arrive,” and “The Wall” that give us a glimpse of what healthcare is like near the Border.

Thank you to my powerhouse team: Ellen, Jerie, Julie, and our team of editors, without whom the current edition wouldn’t be possible. Thank you to all those who graciously shared their work with us, and a sincere thanks to you, our reader. As you make your way through the wealth of experience and wisdom in this year’s issue of Harmony and partake in the courage, pain, joy, and determination of its many contributors, I hope you will agree that the human connection is one of the most powerful forces in medicine.

Sincerely,

Natalie deQuillfeldt
Back on May 2, 1996, the world of medicine to me was just a casual
acquaintance; infrequently visited but at hand if needed. Now, 23 years later, it's
still difficult to comprehend the effects a mere 24 hours can make in changing
one’s relationship with the medical field.

It was only one day later – May 3, 1996 – when our earthquake hit and
we underwent a seismic shift. Our once-peaceful life crumbled, and our
unsolicited journey into the medical arena began. We were scared, vulnerable,
and emotionally taxed. Emergency C-section. Apgar scores of 0, 1, 2. NICU.
Intubation. Fetal hydrops. Loss of white brain tissue. Cerebral palsy. Cortical
visual impairment. Failure to thrive. All words that were mostly foreign to
us, but soon would be commonplace in our ever-expanding vocabulary.

Too, we would become intimately versed in the plethora of medical
professionals: neonatologists, neurologists, neurologists, neurology surgeons,
orthopedics, ophthalmologists, gastroenterologists, pulmonologists, geneticists, anesthesiologists, cardiologists,
endocrinologists, otolaryngologists, urologists, developmental behavioral specialists, and physical, occupational
and speech therapists, and I’m sure there were more.

Over the years, our experiences with medical professionals have vacillated between love and disgust. There
are those doctors with whom we have forged deep bonds. They are not only stellar in their trained specialty
areas, but are equally exceptional in the value they place on patient care. Their ability to show genuine
kindness, interest, respect and willingness to listen, helped get us through times when we felt powerless and
abandoned. These are the physicians who saved us, empathized with us, and gave us hope that we could
rebuild and find normalcy with our new life. These are the good docs. Our heroes.

Then there are the other physicians we met. Really, they are not worth wasting words on, but suffice to say,
their skill in patient care was painfully missing, and our experiences with them were very injurious.

In my role for the Curricular Affairs Department, I have the pleasure of seeing and talking to our medical students
– our future physicians. I am always curious about which road in patient care they will take. Will they be one of
the good guys like Dr. David Milov, Dr. Olga Mas, Dr. Alex Hoon, Dr. Mary Cochran, Dr. David Shafron, and Dr. Sean
Elliott – whose approach embodies the ideal relationship
between patient and physician? Or, will they choose to be
one of the others? While it is a choice they will have to make,
I am hopeful they will embrace the value of patient care, and
be someone else’s good doc. Someone else’s hero.

Being part of the editing team for Harmony has been an
incredible experience. I’ve thoroughly enjoyed viewing
the thoughtful works of all contributors, and working with a
dynamic team of individuals. Thank you Ellen, Natalie and
Julie and of course, Dr. Elliott, for this opportunity!

Best,
Jerie Schulz

Harmony Editorial Staff:
Holly Lawry, Julie Huynh, Tesneem Tamimi,
Natalie deQuillfeldt, Marine Khachatryan,
Jenna Kay, Bianca Kao
MATHIASEN PROSE AWARD: best submission in either poetry or prose

Winner:
THE WARDS: A COLLECTION OF JOURNAL ENTRIES FROM A THIRD YEAR MEDICAL STUDENT by Dilara Onur, page 43

Dilara Onur is a MS3 at The University of Arizona College of Medicine – Tucson. Born in Allentown, Pennsylvania, she spent most of her childhood in the Bay Area. After high school, she moved to San Diego to attend the University of California, and pursued a pre-med major, based on her passion to counsel, educate, and help others, in the context of her academic interest in human physiology and science. Graduating with a Bachelor of Science in Human Biology, she pursued a Master of Science in Global Medicine at the University of Southern California. She traveled to Panama and Taiwan during her studies, which opened her eyes to healthcare systems and cultural nuances pertaining to health and disease around the world. Now in her third year of medical school, she would like to pursue a career in pediatrics, with special interest in pediatric hematology/oncology. She has participated in Docapella and Artworks, two programs that have provided an opportunity to express herself artistically and meet wonderfully supportive and kind people, and has spent time as a Student Ambassador and peer tutor. Outside of school, she enjoys hanging out with friends, hiking, baking, and photography.

RYAN VISUAL ARTS AWARD: best visual arts submission

Winner:
SEEING THROUGH THE WALL by Darian Goldin Stahl, M.F.A, Cover, page 42

Darian Goldin Stahl is an American printmaker and bookmaker based in Montreal, Canada. She is currently enrolled in the Ph.D. Humanities program at Concordia University in Montreal. She also holds an M.F.A. in Printmaking from the University of Alberta and a B.F.A. in Printmaking from Indiana University Bloomington. Darian’s artwork is situated at the intersection of patient narrative, biomedical imaging technology, and multi-sensory printmaking practices. She creates this work in partnership with her sister, Dr. Devan Stahl, who is a Clinical Ethicist at Baylor University and a multiple sclerosis patient. Together, the sisters’ research-creation practice forms a collaborative cycle of informing and reconstructing the illness identity, with the aim of advancing the field of health humanities and fostering a more empathetic relationship between medical practitioners and their patients.

PARADA MEDICAL STUDENT AWARD:
best overall submission from a University of Arizona medical student

Winner:
HASTA UN MUNDO SIN CAIDAS by Claire Lamneck, MPH, page 42

Claire Lamneck is originally from San Francisco but grew up moving across the country including Colorado, Florida, Massachusetts and Arizona. She was motivated to pursue medicine as a means to improve access to quality healthcare among marginalized communities, thus striving towards greater justice. She is currently a fourth-year medical student at the University of Arizona College of Medicine, where she is an upperclass man advisor to the Southern Arizona Asylum Clinic. Between her third and fourth years in medical school, Claire completed a Master’s in Public Health, where she focused on social determinants of health and healthcare equity. At present, she is passionate about immigrant justice and improving the medical care of undocumented patients and patients in immigration law enforcement custody.
The sound of something breaking
The feel of something A C H I N G
The smell of something SickEnInG
The sight of something THICKENING
The taste of something Off eNdInG
Sixth sense of something T R A N S C E N D I N G

Subway Sitter | Rick Kopstein
As a general surgeon, a large part of what I do is talk with patients. Throughout my experiences I have gotten to share a lot of good news with patients. But I have also had to share bad news as well. In medical school we are given brief lectures on how to do this, so a lot of what we learn about how to deliver bad news, we end up learning on the fly, during residency. Eventually when it is time to go out into practice, we have each been shaped and molded by the unique experiences we had delivering bad news during residency. This short story is about one of those experiences that helped shape me.

It was a Tuesday morning during the spring of my final months as a fourth year general surgery resident. As part of our training we had to spend time at a prestigious medical center learning the art of some of the more obscure surgeries that are done. In this case, liver and pancreas surgery. I was sitting in the small office that I shared with five other residents in the surgery clinic, staring at a CT scan on my computer screen. I was perplexed. There was a large mass extending upwards from the patient’s pancreas, where it then wrapped around the stomach, squeezing it, constricting it, making it nearly impossible for food to move through. This was the worst case of pancreatic cancer I had ever seen. Clearly unresectable. Why was she here?

As I continued to scroll through the CT scan wondering what we could possibly do to help her, Dr. Nik, the head of the pancreatic surgery department, appeared at the office door. He was a large man whose presence is rarely overlooked. He had forearms the size of bowling pins, a shiny bald head to match, and a thick Russian accent. If it wasn’t for his long white lab coat, which came down almost to his knees, he could have easily been mistaken as a Russian mobster.
“Why is she here?” He asked in his thick accent, “I looked at her CT scan. I don’t get it. Clearly unresectable.”

“I don’t know,” I replied. “Maybe she wants palliative surgery.”

“Let’s go see her together and figure this thing out. I’ve got a meeting in 15 minutes so let’s be quick.”

We walked down the clinic hallway to the room the patient was in. Dr. Nik knocked on her door and without waiting for a reply he opened it, and we both stepped in. There were three people in the room. Sitting upright on the examination table was the patient, a 61 year old woman who had never previously had a medical problem before in her life. Sitting across from the patient was her sister and her husband. Dr. Nik sat down on the adjacent round stool that doctors always sit on, and his long white coat almost touched the floor. The room was quiet. I stood in the corner, a fly on the wall, waiting for the silence to break. Finally, Dr. Nik, looked directly into the patient’s eyes, and in a soft voice filled with compassion, he said; “Tell me what happened…”

The patient immediately burst into tears. Dr. Nik produced a tissue from seemingly nowhere, and sat patiently as if he had all the time in the world. Then the patient’s sister cut in, “We know it’s bad. We went to Stanford and they told us that surgery was the only option left, her only shot at a cure…” she trailed off.

Then, very respectfully, as if he was speaking to his own mother, Dr. Nik asked, “Why didn’t they do surgery?”, placing emphasis on “they”.

“They told us it was unresectable.”

“I see.” Dr. Nik said thoughtfully, as if it was the first time he had considered this. Then slowly, he leaned over and cupped the palms of his hands together, placed both of his elbows on his knees, and rested his chin on his fingertips. His face was now level with the patient’s sister’s, and they locked eyes. Then, knowingly, like a detective who had already cracked the case and cornered his key suspect, he asked, “And then what? Did they send you here?” again placing emphasis on “they”.

There was a pause. The air in the room was still and the lights felt like they were too bright. The patient sobbed quietly. Then her sister continued, “Well not quite. I was at home watching TV one day and an advertisement came on for your clinic. They showed a man who said that he had had pancreatic cancer that was unresectable. And then he went to your clinic and they resected it, and now he’s cured! After I saw that, I called my sister right away and we got on a plane and came here.”

“Told us it was unresectable.”

“I see.” Dr. Nik said patiently as he leaned back on his stool against the wall, his arms now folded across his chest, and his long white coat barely grazing the shiny linoleum floor. There was another pause. Then the patient’s husband spoke for the first time, “Please help us.”

Dr. Nik didn’t say anything right away, but I knew what he was thinking. In his head he was cursing the hospital for functioning like a business. For advertising like a business and giving hopeless people like this, false hope. And then, when those people showed up, full of hope and expecting a miracle, where were the marketing executives to be found? Nowhere. Not here in the clinic face to face with this dying woman and her distraught family. There was only him, and he had to be the bad guy. He had to be the one to take their hope away. He had to be the one to look them in the eyes and tell them that despite whatever they had seen or heard, there was nothing more that could be done. This burden fell entirely on him.

He sat quietly, considering. Then he unfolded his arms and nodded slowly and said, “Let’s look at her CT scan together.”

Over the next thirty minutes we all sat together and looked at the patient’s CT scan. Dr. Nik explained what it showed and why the tumor was unresectable. He explained why she would be worse off with an operation than without one. He apologized that they had come all this way and that he couldn’t help them. He told them
he really wished that he could. Then they cried and passed around the tissues, and everyone blew their noses. Then Dr. Nik stood up, and as he did, so did everyone else in the room, and they hugged him, and thanked him. He hadn’t cured her cancer, but he had done something no one else had. He had taken the time to help them understand, and by doing so, he had given them the closure that everyone else was too afraid to give them. And for that, they were grateful. He told them to take as long as they needed, and then he and I walked out of the room and back down the clinic hallway.

Halfway down the hall, just to break the silence I said, “You’re late for your meeting.”

The second the words had left my mouth he stopped and turned and faced me, locking his eyes with mine. The intensity of his stare pushed me back against the wall and held me there, frozen. Out of my peripheral vision I could see his hands at the ends of his large forearms were clenched into fists, but I knew he wasn’t mad at me. Then very slowly he said, “Every day is a gift. Don’t ever forget that.”

With that he turned and continued on, disappearing around a corner. I stood there for a moment digesting his words and trying to process everything that had just happened. Then I cleared my throat, blinked my eyes, and went back and sat at my desk. The other residents I shared the room with were all busily scurrying about. Quietly, I turned my focus back to my computer screen, to the next patient’s chart.
She strums strings that ripple sounds through the room.
She sits by his fresh deathbed
Singing sixties songs that light up the gloom.

He says, “I recall when I was a groom –
A cheery young newlywed.”
She strums strings that ripple sounds through the room.

He says, “Our wedding roses were in bloom.”
She plays high notes she once read,
Singing sixties songs that light up the gloom.

She plays the wedding songs of lovers doomed
The moment breast cancer spread.
She strums strings that ripple sounds through the room.

She looks in his eyes as pure darkness looms
And plays as dementia spreads,
Singing sixties songs that light up the gloom.

He’s ending his journey from womb to tomb
With songs in his heart and head.
She strums strings that ripple sounds through the room,
Singing sixties songs that light up the gloom.

The pager beeps and buzzes: code red, code red
It always happens right as I lay down my head
I gather myself and begin to run
Remembering it’s only a few more hours until I see the sun

I arrive downstairs to an all too familiar scene
One man laying helpless surrounded by three dressed in dark green
His femur exposed, jagged and broken
He had jumped the wall; his dreams now unspoken
Fear claims his eyes, and despair his heart
Weeks of walking the desert has led to this part

A pit fills my stomach, humanity is under attack
At last the surgeon shouts for the migra to step back
We care for the man the best we know how
But the honest truth is he would be detained now
Unable to make a phone call or have a moment alone
And sent back to a life which well may be a gravestone

Asylum, asylum: it doesn’t matter how loud you shout it
Without a document or white apellido, you will never be seen as adequate
Illegals, aliens, without papers, a drain on the system
We must amplify their voices and break this hateful tradition
Until all people, of all races, are seen as equal and deserving
Until separating families and finding human remains is more than unnerving
Until the world is just, without borders or walls
Until caring is more than treatment for falls
Monsoon Reduced | Rosie Lizarraga
She fell and bit her lip, revealing layers of fat, muscle, blood vessels, and nervous tissue. I stood in front of her in my short white coat. My mother recently returned it to me after sewing a University of New Mexico School of Medicine patch onto the shoulder after my failed attempt to secure it with iron-on Velcro. I tried to look like something other than a first year medical student. I took care to wear worn slacks, scuffed shoes, and I even hand-creased paper wrappers of tongue depressors and cotton swabs to give myself an experienced clinical look. Despite my efforts, my waist-length white coat was a dead giveaway — I had no idea what was going on.

She was seven years old. I pinched her lower lip with my gloved hand, careful not to agitate the bite. The surrounding tissue glared red and burgundy. Streaks of dried blood traveled away from the puncture, remnants of an attempt to stop the bleeding and clean the blood.

“What happened?” I asked.

“I slipped in gym class and bit my lip. I bit it clean through. My friend said she could see my teeth!” Her eyes were bright. Her face was thin and her long hair pulled back in a ponytail. She wore a white long sleeved shirt with purple sleeves, a sequin floral design on the front, with dried drops of blood above the flowers, looking like rain. Her jeans were worn and her sneakers weathered. She seemed proud of her injury.

“Ouch. Did it hurt?”

“Not when it happened. I didn’t even feel it.” She winced and adjusted an ice pack wrapped in a bloody towel. “I only felt my chin hit the floor. I got up and my lip felt numb. I touched it and got blood on my fingers.” She launched into a story about saving a basketball during a game. The school nurse had called her dad.

When she was finished, I asked, “When did your dad pick you up?”

Her dad answered, “I left work early to pick her up. I got to the school around two.” I noticed him when I first entered the room. His quiet eyes evaluated me. I thought he recognized my white coat. He sat straight in his chair, arms crossed. His jeans were faded and covered in what looked like oil residue. He wore a thick, rough textured Carhartt jacket.

I said, “I need to see the inside of your lip. It may sting a little.” The girl nodded and gripped the edge of the exam table. I rolled her lower lip toward her chin and looked at the shiny, discolored mucosa of the inner lip. Without further agitation of the wound, it was hard to tell if she had bitten through or not. Her teeth were disarrayed, but healthy and unbroken. Her pink gums and tongue were also unharmed. I let go of her lip, separately pinched and tugged on both rows of teeth. They didn’t budge. Satisfied with my exam, I withdrew my fingers and removed my gloves.

With my back against the door, I said, “I’m leaving to talk with my supervising doctor. We’ll both return in a bit. Do you or your dad have any questions for me before I go?”

The girl looked at the wall and whispered, “Am I going to need stitches?”

I didn’t expect the question and didn’t know the answer. I said, “I’ll bring it up with the doctor.”

Dr. Lane was reviewing a patient’s chart at a computer terminal in the staff prep room. She sat hunched over the keyboard with one hand on the mouse and the other holding a half-eaten carrot — a hurried lunch stolen during brief downtime in the chaos of the pediatric urgent care. Her stethoscope lay nearby coiled atop a stack of patient charts. She wore a blue, long-sleeved top and grey slacks. She seldom wore her white coat because, she said, it made patients nervous.

I met Dr. Lane three months into my first year of medical school when she was a group leader for a clinical orientation course. The class arranged experienced clinicians with nervous overachievers. As a first year medical student, I didn’t know what to expect from medicine and I didn’t know what medicine expected from
me. Dr. Lane was a patient instructor and an excellent clinician, having maintained, in large part, much of her empathy for those in her care. After the orientation course ended, all students were required to regularly meet with a physician in clinic to refine new skills. Dr. Lane agreed to be my mentor in the pediatric urgent care and work with me as I learned from my first patients.

I took a swivel chair from a nearby terminal. I placed my notes on my lap and slouched. She turned, asking me how it went. I told her about the girl, her accident, the bite on her lip, and asked if she would need stitches. Dr. Lane shook her head and explained that bite wounds, as a rule, were not stitched. Bites inoculated oral bacteria deep into the tissue. Stitches led to abscesses and more complicated treatment plans. She adjusted her sleeves, grabbed her stethoscope, the patient’s chart, and said, “Let’s go see her.”

Outside the patient’s room, Dr. Lane opened the file and, while reading, reached her hand out to the wall-mounted hand sanitizer, closed the folder, tucked it under her arm, and rubbed her hands together in a fluid, rehearsed motion. She knocked twice, cracked the door, and said, “Hi, my name is Dr. Lane.”

The girl was looking down at her shoes and alternating heel and toe clicks. Dr. Lane continued, “Josh tells me you bit your lip.” The girl nodded and gave a similar version of her story. Dr. Lane performed a physical exam and concluded that the wound may just need to be cleaned.

We left and returned with a bowl carrying a bottle of saline, a catheter, and a large syringe. The girl’s attention focused on the catheter. It was designed with a needle and silicon sheathing. The girl’s eyes followed it from the door to our location in front of her. Dr. Lane handed the girl the bowl, “Can you hold this while I clean your lip?” The girl gave a vacant nod. Dr. Lane took the catheter from the bowl and opened it. The girl saw the needle, widened her eyes, and released the bowl.

“I don’t want a shot!” she proclaimed.

The needle isn’t going to be used.” Dr. Lane removed the needle from the sheathing and dropped it into the sharps container, “See, no needle. All we have is this bendy tube. Here, see for yourself.” Dr. Lane gave the girl the catheter. “Poke your finger.” The girl watched as the tube collapsed and kinked as she
pushed it against her finger. She repeated the motion several times and relaxed.

She picked up the bowl and held it under her chin. Dr. Lane attached the catheter and filled the first syringe. She pinched the girl’s lip a safe distance from the bite and flooded the wound with saline. The girl closed her eyes. Dr. Lane repeated the procedure, calling me over to watch. As the wound cleared, I saw the catheter flash through the girl’s lip telling me she really had bitten through.

When I spoke to Dr. Lane about it two years later, she said she hadn’t seen the catheter pass through the lip. The action was too quick. She thought the wound was only on the outside, a small, but important distinction. From her perspective, the wound was on one side of the lip and thus treatment was within our ability to provide in urgent care. If she had known the bite went through the lip, then we would have either referred the girl to the plastic surgery department for treatment or let her go home after washing the bite.

“Well, now you have a clean wound. Josh and I are going to step out for a minute and we’ll be back.”

Dr. Lane took her seat at the computer, ran her hands through her hair, and looked at the girl’s chart. She opened a medical reference database and leaned toward the screen. She swiveled to face me, “What did you think of the bite?”

“It looked like the cleaning greatly helped. What’s the plan now? Does she go home?”

“Usually, yes. This bite is different from other ones I’ve treated. I’m wondering whether or not we should stitch it.” She explained that the girl’s bite was in a well-vascularized place. The increased blood flow constantly exposed the lip to the immune system. The risk of getting an infection with stitches would be lower than if the bite were in another place. She also said that the lip was a very aesthetic location on someone’s face. Right now, if we let her go home, her lip would heal and leave a noticeable scar. If we stitched her lip before she left, then the scar would be smaller. It may not be a big deal now, but the scar may become more important as the girl ages. Her voice trailed off a moment before she said, “I’ll consult the plastic surgery department. If they say don’t stitch, we send her home. If they recommend stitching, we’ll go and talk to dad and the girl.”

Dr. Lane picked up a nearby phone and called plastic surgery. She nodded and took notes. After a few minutes, she hung up and said, “The plastic surgeon thinks we should stitch. He agreed that the lip has a low risk for infection and the aesthetic benefit of reducing the scar is in the patient’s best interest.

“She looked at the chart again and then back to me. The plan of action sounded reasonable. Enter the room, calmly and clearly explain the situation to the girl and her father, give her some stitches, send her on her way, and feel confident that we did the best we could for her. I was excited. This was going to be my first time seeing stitches given to a patient.

We returned to the room. The girl and her father looked at us again. Expectant. Anxious. Dr. Lane said, “We’ve thought about it and we feel that the bite will need stitches after all.”

The girl turned to her father, color draining from her cheeks. Her eyes glistened and her hands gripped the end of the exam table. “I don’t want stitches,” she whimpered.

Her dad looked concerned, “She’s scared of needles. Why does she need stitches?”

Dr. Lane explained that she got a better look at the wound while cleaning and a cut the size of the one on his daughter’s lip should be stitched. She mentioned her conference with the plastic surgery department and that they also felt the lip could be sutured. She pointed out that although risk of infection usually prohibited stitching bite wounds, the location of the bite minimized the risk. In addition to low risk, the scar would be smaller, perhaps unnoticeable, if we gave stitches. If we didn’t give stitches, then the wound may leave a larger scar as it healed.

The girl’s father stood up during Dr. Lane’s explanation. His presence filled the room. His expression was borderline defiant. “Can we think about it tonight and come back tomorrow if we want stitches?”

continued
“If you came back tomorrow wanting to get stitches, the risk of infection would be too great. We cleaned her wound and if she doesn’t get stitches today, she won’t get them.”

“Okay, let’s get stitches,” he relented.

The girl started to cry, “Will it hurt?”

Dr. Lane reassured, “No, honey. We’ll give you plenty of numbing medicine.”

“Is the numbing medicine in a shot?”

“The medicine is in a shot. It’s a small shot and once we give it to you, your lip will be numb,” said Dr. Lane.

The girl let out full-bodied, coughing sobs. “The shot’s going to hurt. I know it. They always say it won’t, but it does!”

Her dad held her to his chest, one hand pressed her forehead into his shirt and the other stroked her hair.

“What other options do we have? Can we put her under?”

Dr. Lane shook her head, said she was sorry, and explained that general anesthesia was too risky for sutures. She would give lidocaine. Her response was empathetic, but definitive. At the time, I knew that sedation was risky, but didn’t know that Dr. Lane had already considered it. She told me later that she had considered many different approaches to pain management, but eliminated them all in favor of lidocaine. While considering sedation, she worried that an adverse side effect, respiratory depression, might occur and the girl would need to be intubated—an outcome much more harsh than stitches. She also considered giving antianxiety medication, but worried about a subset of kids who became more nervous and had lower anxiety control while on the drug. Drugs like Ativan or Valium could exaggerate the girl’s fear of needles—a negative consequence of the drug and not the girl’s fear of needles. Although lidocaine burned while it numbed, Dr. Lane had used it many times with minimal consequence.

Dr. Lane said, “Josh and I are going to prep another room for the procedure. We’ll be right back.”

“Once out of the room, we cut our way through the congested urgent care toward a supply closet. Dr. Lane hunted around shelves and gathered equipment and asked me to grab a clean sheet from a bottom shelf. She explained that some kids who were afraid of needles tried to use their hands to resist the procedure. If the girl’s arms were at her sides, then everyone, including the girl, was safe from injury. Although I didn’t know it at the time, restraining a frightened patient to keep them from hurting others is common in pediatric medicine. If a child is wrapped in a sheet, the procedure tends to proceed uninterrupted.

I had never restrained anyone in my life and was a little disturbed that the person needing restraint was a child. I told myself that Dr. Lane had years of clinical experience. Safety was her most important priority. If she thought it was best to wrap up the girl, then I wouldn’t question it. With forced confidence, I responded, “Yeah, good idea. I didn’t think about it before, but now that you say it, it’s definitely best to keep her from hurting anyone.”

We took our supplies into a nearby procedure room. We set the instruments on a sterile pad and covered them with a sterile drape. We obtained lidocaine and filled a small syringe. Dr. Lane covered it to hide it from view. We walked to the patient’s room.

The girl had stopped crying and instead showed a quiet tremulousness. Her fear was so genuine that it unsettled me. I was glad I wasn’t in charge.

We asked the girl and her father to accompany us to the prepped room. He guided her into the room cautiously, reflecting what seemed to be his crumbling resolve. In the room, he stood by the girl’s side as we explained to her that we were going to, “make her into a burrito” with the bedsheets. He helped us wrap her. He hugged her before lifting her onto the flat examination bed. He sat near her feet and held her ankles, firm and reassuring.

continued
I took my position and tugged my sterile gloves onto my sweaty hands. Dr. Lane spoke softly to the girl, telling her it would be okay. “I am going to numb your lip now.”

The girl closed her eyes, tensed, and nodded. Dr. Lane picked up the needle and examined the lip, trying to find the right injection spot - not too close or too far from the bite. The needle dove with controlled force. The girl’s eyes leaked. Dr. Lane slowly depressed the plunger while pulling gently back on the needle, injecting lidocaine the entire way.

The now empty needle left a growing bubble of blood on the girl’s lip. She started to squirm. Her face grimaced and she cried. We didn’t tell her that lidocaine burned as it started to work. “Ow, daddy, ow. It burns. It really hurts!”

He looked at us and back to her. He comforted her. It would be over soon and she wouldn’t feel anything. We waited a minute and she calmed down. Dr. Lane injected the lip two more times, the final time injecting small amounts of lidocaine into several areas surrounding the wound.

Dr. Lane ran her finger along the lip and asked the girl if she could feel the sensation. The girl shook her head. Dr. Lane nodded and, away from the wound, increased the pressure of her finger. She quickly removed it and noted the remaining pale spot. The girl’s lip blanched as blood flow was reduced following administration of the drug, a clear indication of its effect. Before she began suturing, Dr. Lane told the girl that the lidocaine only stopped pain and touch. She said this to both the girl and her father. The nerves deep in the lip that sense pressure still work. The numbing medicine would not stop all feeling in the lip.

continued
With one hand, Dr. Lane held the area surrounding the cut. Her other hand contained a needle driver pinching the crescent-shaped suturing needle. Dr. Lane aligned the needle perpendicular to the girl's lip. In one quick motion, the pin pierced the skin and reappeared on the opposite side of the bite. Stitch number one was in place. The stitch site filled with blood. I handed Dr. Lane some gauze and she wiped the lip. The girl yelled. Her dad rose from his post to see what was going on.

Dr. Lane added another stitch and wiped away the blood. The girl continued to sob. The sheet moved and shifted. Dr. Lane unlocked the drivers and placed the needle a safe distance from the girl, simultaneously dropping gauze and using her free hand to steady the girl's head. Dr. Lane looked at me for help. I didn't know what to do, but it was clear I needed to do something. Panicked, I dropped down to retrieve the discarded gauze.

The girl's father acted to help Dr. Lane calm his daughter. He relieved Dr. Lane's hand and he held the girl's head and looked at her. She pleaded to be taken home. She said that she could feel the stitches and that we didn't give her enough medicine.

“She said she feels the stitches. Can she?”

Dr. Lane explained again that pain nerves were numb, but pressure-sensing nerves still worked. She tried a different analogy, “The pressure is the same feeling you get when someone pushes on your skin or lip. It can be odd when that's all you feel. I don't think she's in any pain.”

“She's saying she's in pain and you're telling me it's just pressure. How do I know she isn't feeling any pain?” His voice rose.

“I have given her all of the lidocaine I can and am worried about giving more. I am here to help her. Please, trust me. Watch me when I give stitches.”

Years later, Dr. Lane explained to me she was worried about giving more lidocaine because of its burn. Seeing the lip blanch told her that the current dose was working. Dr. Lane was thinking in terms of net pain versus net benefit. Giving more lidocaine would burn and worsen the girl's demeanor, but suturing rapidly would end everything sooner and the girl and her father could go home.

The girl's father looked at Dr. Lane and then at me. When his eyes traveled in my direction, I looked at the floor. I couldn’t look at him. I hadn’t expected the procedure to be this rough and was preoccupied with my own unease. I wanted only to exist on the fringe of the room, like decoration. As a first year, I was as confused as he was. Now, several years later, I know more about nerve conduction and drug mechanics and my understanding assures me that the girl’s lip was numb to pain, but it's strange how the assurance doesn't bring much comfort. The distinction between pain and pressure and which nerves were active was irrelevant. She suffered nonetheless.

I stood still, waited, and he said, “Okay, I believe you. How many more stitches does she need?”

“Two more and she's done,” said Dr. Lane.

He looked at his daughter. The lip continued to bleed and the girl's cheek and jaw were streaked watercolor red. The blood ran from the edges of her mouth and swirled with tears at the corner of her jaw before streaming toward the once sterile pad under her head. Dr. Lane picked up the needle driver and started again.

I faced the girl. Wet, red, and puffy eyes had replaced the clear ones I’d seen in my earlier exam. I reminded myself: she had two more stitches and it would be all over. I had to get through the next two stitches. I had to convince myself that whatever it was we were doing was the right thing. I said, “Good thing we got a second opinion.”

continued
“What was that about a second opinion?” demanded the girl’s father.

Dr. Lane looked up, confused. I froze.

Dr. Lane answered, “I’m sorry, but what did you say? I couldn’t make it out.”

The dad reiterated, “What was that about a second opinion?”

Dr. Lane continued to look at him, puzzled. She was focused on getting the stitches finished and didn’t hear what transpired. She told me later that her suturing hand cramped while adding the third stitch. Unable to release the needle, she had to use both hands to move the drivers out of the awkward position without hurting the girl. While manipulating her wrist to free it from the spasm, she heard the father raise his voice.

The girl’s father said, with the echo of a pounding gavel, “We’re done here. Now.”

Dr. Lane attempted to protest, but relented, “I understand. But, please, before you go. I’m halfway through a stitch. Can I finish this last one, tie off the suture, and then stop? If we stop now, then the stitch already in place will not hold and should be removed. I promise that once I’m done, I’ll help you and your daughter out of the clinic.”

He gave permission for one stitch and one stitch only. As Dr. Lane finished the final stitch, the girl squirmed in the sheet wrapping. She wanted to go home. Dr. Lane helped the girl’s dad unwrap the sheet. The girl’s father hugged her. Her bloody face imprinted his shirt. Her wound was, for the most part, stitched. The end not yet sutured, remained open and raw.

Writing about the situation now, the wound seems symbolic of our encounter with the girl and her father. We tried to contain the girl’s phobia and earn the trust of the girl’s father, but his daughter’s fear of needles trumped our efforts, and likely would have overcome additional effort. Dr. Lane acknowledged this reality when she ended the procedure early at the demand of the girl’s father. Other physicians might have had the father removed from the room, but Dr. Lane didn’t. The girl’s father forced an intersection between the clinical course of action and a reasonable course of action. The minimal risk of stopping the procedure wasn’t enough to outweigh his decision, so she stepped aside.

After the girl, her father, and Dr. Lane left the procedure room, I glanced around. The white sheet lay piled on the bed, covered with red dots, like someone flicked a dipped paintbrush toward a blank canvas. Dr. Lane’s bloody gloves and hemostats were on a stainless-steel tray holding what was left of our gauze. I took off my gloves, sat on Dr. Lane’s stool, and wiped my face with my hands. Dr. Lane returned a few minutes later, seeming flustered, but relieved the case was over. She looked at me and asked, “You okay?”

“Not really. I feel bad about what happened.”

“It wasn’t your fault. The girl was afraid of needles and wanted anything but stitches. Her dad just wanted to protect his daughter.”

I looked at her. She smiled and said there was a final patient waiting, but that it was the end of my shift. “It was a big day for both of us. If you want to talk about what happened today, please let me know.”

I nodded. Nursing and other staff replaced our presence in the room. I gathered my things from my locker and left.
strobes flashing
alarms
seventeen people
a flurry of health care

blue scrubs
white coats
conduct a score of monitors
flat
then
jiggy
then
jaggy

nurses dance in tandem

palm
over
palm
over
chest

compressions
continuous
compressions

synchronous
blue shoulders
push
rise
push

the flaccid belly
rolls
and
rolls
in the waves

nurse washes
and washes
broken bones
from her palms
Today was my first day in the anatomy lab. We were (not so) formally introduced to our teachers for the next year and a half, our long awaited cadavers. As we huddled anxiously in ill-formed groups, we were told to “expose the muscles of the posterior thigh and glutes, clear away fat and fascia, and to make [our] your space clean at the end.” Never had I ever had such little direction with so much to gain in front of me. It was simultaneously riveting and overwhelming, akin to stepping off the diving board with your eyes shut. I jumped.

I marked my name on my fashionable apron, gloved up, put on sleeve protectors, and grabbed a 10 blade on a #4 handle. This was immense progress from the first week of med school, where the thought of stepping into the anatomy lab surrounded by freshly passed bodies made me weepy and ill. The first incision was a T shape on the back. I recall this cut—it was dry. I did not know the tension of the skin that would meet my knife—it was a deeper cut than I anticipated. My eyes remained fixed, as if I were waiting for him to call out in pain. The luxury of a body that could not speak back was certainly helpful in times like these. My colleague and I had to traverse a decent amount of fat before we reached shiny, beautiful fascia. The fat was this bright yellow thick gooey-ness that made me churn at first; it had a mustard-like appearance and thus I avoided mustard for some time thereafter. After the fat we encountered fascia in its shiny gloriousness. Little did we know that day, fascial planes would become our very best friend over the next year.

It is only reasonable to pause and introduce you to our cadaver, although I personally found it best to avoid attempts to humanize that which laid before me—this approach kept me perfectly balanced and detached to do my job. Sometimes the hands would be beneath the area where I was trying to work—the nail beds pooled with blood— and I would look away or cover them. Chester, the name our group of five bestowed upon our nameless teacher, was 93 years old. On this day, he had become ours to cherish and learn from. As a team, we would make use of each corner of skin, each vessel, tendon, muscle, and nerve that we encountered.
By the end of about five hours we had thoroughly exposed the majority of his posterior muscles and made (relatively) clean back flaps. Our group was exhausted and some of us couldn’t feel our thumbs for we had been clamping hemostats for hours. Despite the numbness, it was a day to remember.

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**September 11, 2019**

Today was my first day making an incision on a living patient. Today also marks two years since my first day in the anatomy lab. The timing of these two events could not be more resonant with meaning.

As is typical fashion on one’s surgery rotation, I scrub in last and join the party at the operating table, adjacent to my attending nestled up to the patient’s side. I aim to touch nothing and keep my hands in a sterile bundle at my chest. I also think this will somehow make me invisible and that I will blend into the surgical drape as a big blue smurf, allowing protection from pimping questions. However, today my camouflage tactics failed me. On this particular day, my attending saw the natural curiosity in the eyes behind my fogged up glasses. Today my attending asked me to make the first incision. At first I believed it was a mistake; that he was talking to the resident across from me. For about one second I pretended he was talking to an imaginary friend perhaps also conveniently situated next to me. In typical surgery rotation fashion, I said “absolutely” with firmness even though I was outright scared. I asked the scrub tech for the scalpel, declared incision, and began cutting, palming the scalpel carefully but with conviction. We were performing a wide excision of a skin cancer and the incision resembled the shape of a football. The attending coached me through and told me to cut deeper, dabbing with a cloth as blood slowly began to ooze. “Deeper, deeper” he said. There is no asking in the moment, only doing and having trust in the senior scholar at the table. “Knife back,” I told the scrub tech, as if it was the period at the end of a sentence, a declaration of completion. I did it. The case swiftly carried on. Toward the end, I assisted in closing the incision that I had made, slowly executing the subcuticular stitch, a suture that beautifully pulls the dermis together. Placing steri strips on the incision was a humbling moment; I wanted to keep it dry and perfect. It was a finished product, my finished product.

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These two time points mark an evolution in my training, an evolution not just in physical skills but also rather in an approach to the field of medicine. This field is marked by continuous change. It is a current that shows no mercy, taking all in its path. Every day presents a new experience. Often these experiences are disconcerting, but we must approach them with ease and comfort. We jump in albeit we feel scared and uneasy. We jump in because we must start somewhere. We close our eyes and jump.
Tachycardic elevation
I lost the beat - should I chase it?
In this chest, it is racing
I can hear reverberation

Stutter step, dysregulation
Feel this voice, cannot raise it
Feel it shrivel, like a raisin
Feel a flutter, palpitation
Feel it sink, feel desperation
Feel the fear, should I face it?

Feel the momentum of the pace
Feel the sweat upon this face
Feel the dread of letting go
Feel relief, I can taste it – Stop

RETURN of circulation
Am I here, am I adjacent
To this body, this habitation?
I cannot help but contemplate
The finality of all beings’ fate
Whether it is reincarnation
Or just permanent cessation

Why do I fear the separation
Why do I feel you fear it too?
What would it be to be courageous
To come to know it like the truth?

Do you wonder, on occasion
Acolyte, your hands with careful placement
Upon this sternum, in oscillation
Do you perform this investigation
Or leave these thoughts only to patient – Stop

RETURN of circulation
Ventricular fibrillation
If you could hear this ECG
This heart’s own radio station
Would you hear cacophony
Or discern a new vibration?

I suspect you feel me fading
I can feel you fading too
I can feel a warmth invading
Someone is calling, let it through–Stop

RETURN of circulation
Should Lazarus fail in my salvation
Let this be my final statement
Once this shell has been shaken
May the third eye awaken
May this mind be sublimated
As this body lay in prostration – STOP
Our police escorts drove between 70 to 100 miles per hour, with only four to ten feet between their cars, swerving across the dirt road, the “highway” leading into Grozny. This tactic aimed at reducing the chance of being hit with sniper fire or blown up with a landmine. In our car the tension mounted with every second. Alek, our Chechen driver and host, followed closely behind, swerving along with the police cars. The tires tuned up clouds of dust behind us on the highway which had been closed a week earlier due to heavy sniper fire from the Chechen forces. It was August 20, 2005, and we’d already spent six days in the North Caucasus.

Despite feeling weak and dizzy, I felt determined to stick with our mission to assist the injured and ill in Grozny. It had been an anxious morning for our group. We’d already driven across the border from Nazran, Ingushetia, our home base, to the volatile outskirts of Grozny, the capital of Chechnya. Crossing the border from between Nazran, Ingushetia and Grozny, we passed through three army checkpoints, manned by Russian guards in helmets and kevlar vests and armed with AK-47s. Huge men with ruthless eyes, they looked like they’d pull the triggers of their automatic weapons at the slightest hint of provocation. They narrowed their eyes and stared at us, slowly scanning our faces then comparing them to our passports. Each time their icy eyes lifted from the passports to us, the rope of tension between us and them pulled a little tighter. Their suffocating gaze pressed down hard on us, and their angry silence held the possibility of explosive violence. It made it hard to breathe. Fear was something I had rarely experienced directly. Finally, they waved us through. By the time we cleared the third checkpoint, the car smelled of sweat.

As we entered Grozny, we passed a fortress that stationed thousands of Russian troops and hundreds of large tanks, a military base that put the city in a stranglehold. No one came into or out of Grozny without Russian approval. And the consent at best felt grudging and reluctant.

After clearing the check points, we met our local escorts, who’d bring us further into Grozny—two young, Chechen policemen, scrawny, wide eyed, and dwarfed by the brawny slit-eyed Russians. The thin duo greeted us with grim expressions. Their uniform pants ended around their ankles and were tightly belted to keep them
from falling. Their shirts hung loosely around their emaciated bodies. Now they drove at breakneck speed and swerved all over the dirt road. I winced at the expectation of a bullet crashing through the window or a bomb exploding beneath the car. The feeling of that trepidation still reemerges in my nightmares.

Americans are prime targets for kidnappers in poor, war-torn countries. We found out later that simply by escorting us, the Chechen policemen had put their lives at grave risk. Grozny means “fearsome” in Russian, as in Ivan Grozny or Ivan the Terrible. The name fits the city perfectly. Death and destruction were everywhere. Block after city block in Grozny showed a ravaged wasteland scarred with the detritus of bombings and battles: soldiers, guns, tanks, rocket launchers, maimed civilians, and everywhere the wreckage of buildings and streets.

By now I was rethinking the wisdom of coming. It had taken three years of waiting before we were finally cleared and “invited” by the Russian government into the volatile and war-torn area of the North Caucasus and Chechnya. I had no idea it would be this bad, nor did Dennis, my partner in this undertaking. We’d never imagined this level of human suffering and physical devastation. Back in New York, Dennis had asked me to book a nice hotel in Chechnya on-line and, scanning the Google images, I told him, “Dennis, there are no hotels, only bullet ridden buildings of the few left standing.” Still, seeing that in pictures and videos and being there in it are as different as a breeze against the face is to a kick in the stomach.

Dennis should have asked me to book us a foxhole. There we were: two New Yorkers putting our lives on the line and those of our hosts to burst into a war zone so we could start a running program for the disabled and give help to the sick. If not for the fact that the program enabled us to obtain medical aid for the isolated and forgotten, our venture would have been patently absurd.

We’d also hoped our visit to Chechnya would transcend cultural barriers and be a small contribution toward peace. More than 30,000 children had died in the Second Chechen War for independence from Russia. Children here experienced war, terrorism, and kidnappings on a daily basis, while their country remained isolated from the rest of the world. The Consolidated Appeals Process, an advocacy tool estimated more than 2,000 children under the age of three would die each year as a result of inadequate medical care. As foolish and risky as the trip might have seemed to my family and friends, I felt I had been blessed with much and had a duty to reach out to those suffering. If only my motives had been that simple and pure.

We arrived at the former press house in Grozny, now a collapsed pile of rubble surrounded by bomb craters. Everything looked gray. The few bullet riddled buildings left standing, showed gaping holes, craggy and jagged walls, and sagging foundations. From blown-out windows women hung clothes to dry on lines. Amidst this appalling squalor, 90,000 to 190,000 Chechens made their home. When the USSR collapsed in 1991, Grozny bustled as a gorgeous modern city, proud of its culture and education. Now I watched from the car window the destruction left me feeling stunned and confused. You look at ruin, you feel ruin, you can become ruined.

I met Dennis at the 2000 New York City marathon. The president of a running club for the disabled, he struck up a conversation with me, after seeing me guide a disabled athlete across the finish line. Acting as a disabled running guide, I supported Jim, an above the knee amputee from Jamaica, through the last half of the marathon. Although I was not an official runner, this inspiring experience marked my first running race and half marathon. After finishing, I was hooked on the running bug. Eventually I would compete in ultramarathons and Ironman.

After we got to know each other, Dennis kept trying to have sex with me. A short, fat aggressive man, he rarely stopped pursuing what he wanted. “Dennis,” I’d say, “It’s never gonna happen.” Yet, when not having to resist his unwanted advances, we worked well together, and I loved volunteering. I enjoyed serving as a guide to disabled athletes through many running races. In 2001, I was tethered to lead a blind man, who weighed twice as much as me, to summit Mount Kilimanjaro.

Dennis, an above-the-knee amputee, had started a running club for people with all kinds of disabilities, and membership in this club has been a life-changing event for many who lost a limb, suffer blindness, or
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battle chronic illness. It was certainly life-changing for me. Being born legally blind in my right eye due to a post lenticular cataract, I ran my first marathon in New York City, as a disabled running athlete, in 2001. My race time for the New York City marathon was 3 hours and 43 minutes and I qualified for the Boston marathon, which was my second one and finished it, in 2002. I was stoked after finishing the Boston Marathon in a time of 3 hours and 30 minutes, which was running an average of an eight minute mile flat for 26.2 miles.

As a trauma expert who ran the psychiatric emergency room at St. Vincent’s Hospital Medical Center in New York City, I’d seen plenty: patients who were psychotic, suicidal, violent, homicidal, homeless, mentally ill, and chemically addicted. The day after September 11, 2001, I crossed police barricades to volunteer at Ground Zero and offered crisis counseling to firefighters and family members who’d lost loved ones. Before that, I helped cancer and AIDS patients die with dignity and comfortably free of pain. Yet, none of that would prepare me for the desolation of the Chechen genocide.

Lying between Eastern Europe’s Black and Caspian Seas within the Russian Federation, the North Caucasus comprises seven ethnic homelands and is a mosaic of 50 different languages. Chechnya has struggled for centuries under Russian domination, and its declaration of independence in 1991 led to war, the most recent in 2005. Aside from issues of territory and resources, a major cultural difference responsible for the ongoing conflict is religion. Instead of the Russian Orthodox religion practiced in much of Russia, the majority of Chechens are Sunni Muslims.

In August 2005, I travelled to Chechnya with Dennis, not simply as a disabled running club athlete and ambassador, but as a physician. We met our hosts at the Moscow Airport. Natasha presented herself as a Czech crusader for the Chechens and functioned as our interpreter and cook. Igor Smirnov claimed to be a Reuter’s sports journalist. Corpulent with cherubic, high cheekbones, Natasha continued
welcomed us with open arms. Igor, who finally got permission from the Russian government for us to enter Chechnya, shadowed us for the entire 10-day stay in the North Caucasus. He reminded me of Napoleon: small, 5’ 4”, very stout and muscular. He was in his early 40’s—my age. His blue-gray eyes were cold. I didn’t like him on sight.

We were tired and hungry when we arrived in Moscow. Igor hurried us along into a waiting black sedan with a driver in the front. He ignored my request for water. When Dennis handed me his bottled water, Igor smirked and barked, “Dennis, we have a long drive and you’ll get thirsty.” Almost immediately I noticed that my presence annoyed Igor. I’d later learn that Igor and Dennis were old buddies, working together to set up many disabled running club chapters in Russia. Dennis had also helped Igor get into Bronx Community College and find an apartment in Coney Island.

After piling in, Dennis in the front seat and me in the back between Natasha and Igor, we drove off for a farmhouse in the countryside in order to rest before our early morning plane that would take us to our final destination, the North Caucasus. The car windows were tinted and I had a hard time seeing through them.

It felt like I’d entered a coffin. My chest became tight and cold sweat trickled down my ribs. I felt cramped between Natasha and this swarthy, sneering man. When my request to use the bathroom fell on deaf ears I became nervous. I glanced over at Igor who had a sardonic smile plastered on his face. I leaned forward and whispered to Dennis, “Say you need to use the bathroom.” In seconds, we raced to the closest bathroom. Deep down, I knew something was not right. But what could I do? I was here already and unless I grew wings and flew out of the car and across the ocean, here is where I’d be for a while.

My nervousness started to creep into the terror zone. The people I was traveling with were supposed to be friends. Dennis remained impervious to my rising discomfort. I’d prepared myself to be ignored by the Muslims. But this? Already? Suddenly, I felt crushed between Natasha and Igor and could not get my breath. My throat closed up. My heart jackhammered in my chest. I broke out into a fresh pool of cold sweat. My mind screamed, Nina what have you gotten yourself into now!

Struggling to clear my throat, I cried out, “I need to get out of this car right now!” My companions were shocked. I climbed over Igor, who sneered at me and did not move, jumping over him, and out of the back seat. I told Dennis I was claustrophobic and wanted to switch with him. When I got into the front seat of the sedan, the atmosphere became sullen. My being a woman and having a voice was not welcomed by my Russian hosts. They now regarded me as a pampered, silly little American woman who did not know her place in life.

Once in the front, I breathed easier, though I could feel Igor’s hostility searing a hole through the upholstery behind me. Natasha, suddenly shouted, “Nina, pull your seat up as far as it goes.” I rushed to comply, not wanting to take up any more room.

The driver spirited us to a small house just outside Moscow in the Russian countryside. Outside on the lawn, a German shepherd tied to a tree yanked at the rope, the collar pulling hard at his neck as he barked at us ferociously. I could see his snarling teeth in the darkening air. When we entered the house, Natasha asked us to wait. Dennis and I stood in the foyer and watched as the backs of our hosts disappeared into the house. Natasha went upstairs and Igor down the hall. I collapsed in a chair, glad to have a moment alone without their orchestration.

Thirty minutes later, Natasha descended the stairs with a tall, Russian man. He was disheveled, shaking, and emaciated, with a suitcase in his hand. As Natasha interpreted, he told us with a shy grin that he was not well and had just gotten out of the hospital. His reddish nose, shaky limbs, and jaundice color strongly suggested the look of a chronic alcoholic. For a moment, he and I looked closely at each other, and his death’s-head smile made my skin crawl. After he left, Natasha closed the door and stood beside me. “Are you okay?” she asked. “Yes,” I answered, shaking off the goose bumps.

“This way,” she said, and we returned upstairs where she showed me to the bedroom the man had just
occupied. When I slipped between the sheets, the bed was still warm from his body. Dislodging myself, I slept on the top sheet, despite being cold.

The next day we travelled in the black town car to another Moscow airport to fly to Nalchik, Kabardino-Balkaria, a province in the North Caucasus. Our group boarded an old Soviet plane for the short flight. There we met our Chechen hosts, Alik Galayev, a deputy minister of Chechnya for “Unusual Situations,” and his brother, Ahmed Galayev, a handsome Chechen businessman. War was usual in Chechnya, volunteers to help were not. We were the “unusual situation!” Ahmed, a friend of a general whose house we would be staying at, lived there with his wife, Jana.

Alik looked much older than his 49 years; gray hair, pallor and tired around the eyes. Ahmed drove in a car by himself in front of us. Alik drove the second car with the rest of us in it. They drove us to Nazran, Ingushetia, the last republic in the foothill of the Caucasus before Chechnya. In route, we encountered two roadblocks. Local Ingush policemen ran the first. They checked our passports, looking over them slowly and carefully, then looking at us coldly. At first they cleared us, but then held us back, saying their computer wasn’t working and they could not confirm clearance. Translation: we hadn’t tipped them. Our Chechen hosts remained unfazed. After we coughed up the rubles, the computer buzzed to life. They explained that this is customary and equivalent to tolls on roads in the United States.

At the second roadblock, Russian policemen with Kalashnikovs rifles strapped to their sides checked our passports. Their eyes felt even icier than those of the cops at...
the first road block. Eyes looking for a reason to hurt. At this moment we stood before the abyss. A real possibility of violence or kidnapping loomed. Natasha asked me if I was scared. I said no, and I was telling the truth as I was not in touch with my fear. It was only after I returned home to New York, that I thought about how easily and in how many ways that moment and many others could have turned deadly. I wondered why I had not been more fearful, except for that time on the first day of the trip when I felt suffocated between Igor and Natasha and had to exit the car.

As we waited for permission to enter Nazran, Ingushetia, unfazed Muslims carried out their daily activities. I caught a glimpse of young, stylish Muslim women wearing westernized, A-line, mid-calf skirts. They carefully negotiated the unpaved roads wearing high heels, their heads covered in dark monotone scarves, carrying groceries. In this place, where disasters and destruction occurred regularly, fashion still held firmly in place.

Finally, Dennis and I were interviewed by an agent of the Federal Security Service of the Russian Federation in Nazran. He spoke fluent English with only a slight accent. He was tall, fair-featured, and perceptive. After a 45-minute interrogation, he wished us good fortune on our mission and indicated that we were only the third and fourth Americans allowed into the area during the Second Chechen war. Doctors without Borders had left after one doctor was kidnapped and eventually murdered.

Home base for us during our stay was a general’s house in Nazran, about an hour’s drive from Grozny. The house, fortified by 20-foot gates, resembled a fortress, and stood out, like a huge pimple-shaped eyesore from the bucolic landscape. Rolling farms, with grazing cows and horses surrounded us. The farmers lived in small huts made of mud and straw. Neighbors, who the Chechens called gypsies, showed up regularly, outside the gates, begging for food and money. The interior of the cavernous house was decorated in heavy wainscoting and seemed an odd juxtaposition to the rustic countryside. Our indoor plumbing with toilets and showers was both an oddity and luxury for the area.

After a day spent working in the refugee camps in Ingushetia, we returned to our safe haven each evening. Jana, Ahmed’s wife, greeted us with meals of potatoes, pickled vegetables, platters of sliced meats and watermelon. Though she prepared our meals and cleaned up after us, she chose not to socialize. When I tried to clean off the table, she sweetly smiled and shook her head, pointing for me to sit down. She was attentive to all our needs. She brought us cold Russian beer, which she knew I enjoyed very much. Her young daughter, aged 10, also lived in the house, but the woman and children ate by themselves.

More than half of the Chechen population had fled and now lived in the refugee camps. At one, the smell of human waste permeated the air. A lonely farm field, under electric wires, littered with abandoned Soviet train cars, was now home to more than 3,000 Chechens. These deeply traumatized refugees knew they’d been discarded and forgotten by the world. They did not even have basic sanitation. We were introduced to the chief of the refugee camp who told us his 13-year-old daughter had a viral infection and was unable to fight it, and had subsequently developed viral congestive heart failure. The refugees, he said, complained of constant headaches, which they believed were caused by the close electric wires overhead. Each evening, after providing medical care to those lying in the camps, we returned again to our safe haven.

At another refugee camp, I met Makka, a 15 year old blind girl. She’d lost her vision at the age of nine playing outside her house when a car bomb exploded. No medical resources existed here to provide her treatment. Upon learning we could offer medical intervention, she was taken by the deputy minister of sports to a hospital in Moscow. Her medical assessment revealed that a corneal transplant would restore her vision, and she eventually was able to get the surgery to regain her sight. Helping girls like Makka was why I had come.

I felt at odds with my American traveling companion. Dennis’s altruism, while well-intentioned, wasn’t exactly pure. He wanted good press for his disabled running club to appear in the local papers back home, with photos depicting his brave heroism. After a few beers, he’d get a little too flirty. “Dennis,” I would say, reminding him of the rules we’d set out before we boarded the plane in New York. “No.” We had agreed that during this humanitarian trip, Dennis would leave me alone, respect my feelings, and stop trying to sleep with me.
While Dennis looked for Chechen photo ops, Igor looked for someone to hate. He seemed to dislike everyone, except Dennis, but he reserved a special hatred for me. It’s not hard to tell when someone harbors such feelings for you. Sometimes a single glance reveals envy and hatred. I was an elite athlete, successful physician, and an American woman, less subject to the extremes of patriarchal oppression so common in Russia. When Dennis told Igor that I was doing my first Ironman in three months, Igor became belligerent, “Dennis, you’re exaggerating the distance,” and started cursing in Russian. He went outside and began furiously throwing a ball against the outside of the general’s house. Jana became alarmed and disappeared into the house. Alik turning red, quickly excused himself from the table. Dennis and I were left at the table alone. Igor’s temper tantrum continued for several hours.

While using the downstairs bathroom, the door was suddenly opened and Igor appeared. Despite being fully clothed, I became enraged and screamed, “Get out!” Igor smiling ruthlessly said, “Get out of my bathroom and do not use it again.”

Avoiding Dennis and Igor, I spent time with four Chechen girls Jana introduced to me, her daughter and relatives between the ages of five and twelve. The girls enchanted me, teaching me Russian words by drawing pictures and then suddenly grabbing my hand to guide me through several ethnic dances. I felt free in my body with them as we twirled together on the patio inside the gates around the house, then collapsed in laughter. Their joy and passion was contagious, but the back of my mind darkened with fear for their future. I wondered if this place might break their spirits. Upon our departure, they gave me jewelry and other trinkets, and I kissed them on the tops of their heads where they parted their hair.

On the third day of our stay in the North Caucasus, Dennis, Igor, and I had lunch on the patio, enclosed by the towering brick walls. I loved beer, and had been known to opt for a lager, rather than Gatorade, after a workout. The sun shone brightly that afternoon. I took a sip of an exotic Russian beer that Igor brought me in a glass. Usually Jana would bring Dennis and me the bottle, which I drank out of directly without a glass. This time I noticed a strange sediment at the bottom of the bottle.

Sitting in the bright sun on the patio ringed by the protection of 20-foot walls, I noted the sediment, but I did not entirely trust my intuition that something was wrong. I excused myself to go to the bathroom, and when I returned, I had one more sip, but refrained from consuming any more. After drinking that beer, my health, a robust friend I’d always taken for granted, deserted me.

Later in the day, I developed flu-like symptoms, fever and muscle soreness. In a couple days, I became violently sick, with projectile vomiting and bloody diarrhea, high fever, intense abdominal pain, dizziness, lethargy, extreme weakness and headache. I was delirious and unable to get of bed for three days. I never had a doubt about what was happening to me. I understood instinctively, almost impassively, what had occurred, as if I were my own emergency room patient. I knew I had been poisoned, but I did not know with what. In the morning, weakened, while still in bed, I informed Natasha and Dennis that I had been poisoned. They seemed nonplussed and had no response at my self-diagnosed condition, both perhaps genuinely unable to process this information. Five years later through various research and explorations, I discovered that many of my symptoms were consistent with anthrax exposure.

“Where is Igor?” I asked, and Natasha said he had left to report a story for Reuters at a local building in Ingushetia. Natasha and Dennis left shortly after this conversation, so Natasha could take pictures of Dennis milking a cow on a nearby farm. I remained in bed for several days, slipping in and out of consciousness, too sick and weak to move. I continued to have dizziness, high fevers, headache, and severe abdominal pain. Jana brought me lovely, thoughtfully prepared meals on a tray, but I was too sick to eat them. She wiped my head and sat by my side the entire three days. There was no medical help available. I was the only available medical care. Even if there had been doctors, there were many others who also needed acute intervention. In three days, I lost 10 pounds that I could not afford to lose.
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I simply could not get up, could barely even lift my head. Dennis showed little concern. It was food poisoning, he opined, or just a bug. On our last day, weak and still running a fever, I determined I’d go to Grozny, even if I had to crawl. That Russian bastard would not win; he’d see me on my feet again. After struggling to get out of bed, I came downstairs. Seeing me standing, Igor looked shocked. Dennis confided, “Igor told me the others did not like you.” I laughed at the absurdity of this. While I was sick they had visited a refugee camp. The leader of the camp had offered two of his wives to Dennis. Dennis politely refused and told me that the women were fat and unattractive, “but they missed the best time they would ever have.”

In Grozny, we met four emaciated Chechen girls who were part of a local winning soccer team. Anna was a 14-year-old Chechen who had lost her left leg and hand to a land mine while playing outside. She told us she lived with her mother and that the Russian army had kidnapped her father. In a shy, humble demeanor, she explained her love of computers. We brought sneakers and shirts for her and the other children we met so they would be able to race with their new disabled running chapter. Meeting Anna and her teammates powered me through the day, though I had to take frequent rests to catch my breath on low stone walls and benches. As soon as we returned home to the general’s house, I collapsed back into bed.

On our last night, we heard a loud explosion from outside our protective wall. I asked Natasha what the explosion was. She answered it was fireworks. I did not believe her. While boarding our plane from the North Caucasus to Moscow, in the local newspaper, we learned that there had been an assassination attempt on Ingush’s Prime Minister, Ibragim Malsagov. He had been responsible for permitting us to enter the North Caucasus. The two roadside bombs killed his driver and wounded two others. The prime minister was hospitalized with wounds in his hand and leg. The two explosives, placed ten meters apart, detonated within ten seconds of each other as the prime minister’s motorcade passed.

It was one more sign that it was time for us to leave Ingushetia. On the last day of our stay, while in Kabardino-Balkaria, Natasha, Igor, Dennis and I visited the majestic Mount Elbrus, the highest mountain in Russia and Europe. While standing on some very high cliffs overlooking dizzying drops, feeling quite ill and shaky, I saw Igor staring at me and our eyes locked. In that moment our communication occurred solely through eye-contact, an ancient animal reality. I immediately realized he wanted to push me off the rocky precipice on which I stood and was on the verge of deciding whether to do it. There was no one else around. Seeing his intention, I glared at him in fury, thinking to myself, Go ahead, you son-of-a-bitch, just try it, and I’ll make sure you come with me! Seeing my unwavering determination to take him with me to the bottom of the valley, the hate lamps turned off in his eyes, and he looked away.

Dennis, Igor and I were looking at groceries that Natasha was buying for our last dinner. Dennis asked me for money to buy a memento, as his had been stolen, several days earlier. After his money was stolen, Dennis became alarmed and carried both of our passports in the front pocket of his shirt. With Igor watching, I rifled through my knapsack to find my runner’s wrist band, where I kept it. I gave Dennis some small change. The next morning, I noticed Igor stuffing something into the front of his pants. That was the last time I saw Igor. He left soon after that, without saying goodbye. Natasha brought us to the airport to return to Moscow. Hugging her goodbye, I wanted to give her my money to help sick refugees to get sorely needed medical attention. I searched my runner’s wrist band, and the three thousand dollars was missing. Natasha stated, “It makes me look like I stole it.” I remarked, “It is only money and do not worry, I know who took it, and he is not here.” Russia had robbed me of my health and money, but I was still alive. It was time to go home.
Rainbow Woman, I summon you
after the storm of surgery
and melee of medical interventions.
May I reclaim calm after clamor.

May I rise to your arching way
to join above and below
in full vibrancy
to span and bridge,
uniting.

Calling on my own heritage
of wonder and light,
May I magnify full spectrum:
red, orange,
yellow, green, blue, indigo,
violet.

Rainbow Woman,
embrace me
as I whirl the changing colors.
Let my eyes drink in
each hue
and know each tone and quality
through and through
as I settle into
your promise
of healing renewal.

***

Note: In Navajo and Hopi traditions, Rainbow Woman
brings healing light and nurturing rain.
10:54:45
I write it on my hand so that I will not forget.
As if I could forget.

You have already been here a week.
When I meet you.
I’ve seen your face while we round.
You’re having trouble breathing.
You’ve got a high-flow oxygen tube in your nose.
That’s all I really know.
Your blood pressure dropped overnight,
And we don’t know why.
This morning, we are running many tests.
We come in with the intern,
and he lets us ask you questions.

My colleague knows the questions to ask,
And I sit back as she takes the lead
But I can see something in your face
A sort of quivering.
When she goes to report to our intern,
I take your hand.

“How are you feeling?”
The look in your eyes almost melts me.
“I’m scared.”

I tell you that it is okay to be scared,
That what is happening is scary.
You don’t say much more but you hold my gaze
Until tears run from your eyes.

I do not look away.
I know what it is like
To want someone to witness your anguish.
You apologize.
I grasp your hand harder
Until we are interrupted.
I promise I will come back.

I see you again that day.
You are less scared.
Your daughter is coming.
I ask my resident if I can be put on your case.
When he tells me you are going to the ICU,
I feel some pause.

I go to see you one more time.
This time, I meet your daughter outside.
She asks me what has been going on-
I retrieve my intern for her, and he gives
her what we know
(Which isn’t much)
I comb the chart, trying to understand. Heart failure. That's what they thought it was. But after a week of treatment, you are no better. Something else, then.

We get a bronchoscopy. You get worse. You need help breathing. More help breathing. We put you in a mask that pushes air into your lungs. You don't like it, but it keeps you alive. I come to see you. I hold your hand.

The next time I see you, it is in the ICU. You can't speak well. For the next few days, I pull out the alphabet board. You sign words for me. On the first day we do this, you ask for this or that. On the second day, you write, “you are good” On the third, you are too confused to sign; I ask if it is your brain or your muscles. You indicate that it is both.

You come off the BIPAP, the breathing mask, for 12 hours. We are hopeful. But it does not last long. You go back on.

We have run innumerable tests. All negative. You can't breathe And we still have no idea what is going on. But we have our fears.

If you are to live, we have to put you on a vent. We have this conversation. Your daughter knows your wishes. You agreed to this a few days ago, provided it was just a temporary measure. We decide to obtain a biopsy and then leave you on the vent afterwards, So your lungs can rest. It seems a reasonable plan.

I come to your room Just before they take you. Your daughters are there with you I meet your oldest. You are confused. The younger one explains What is happening.

You still don’t seem to understand. I offer to walk with you to the OR. I hold your hand in the hallway.

Just before you go in, You ask me what is happening. I explain it again. I don’t think you understand me now either. There is fear in your eyes. Maybe it's just that you know something That I don't.

On the vent, You are sedated to keep you comfortable But you open your eyes and wiggle your toes when asked. When you stop opening your eyes to the formal name I've called you, Your daughter tells me to use your nickname. You respond again. At least for now.

You are Stable But not well Not getting better The days waiting for the biopsy results Are long. Finally, I go to the lab. The pathologists are kind. One reads the slide to me. Your lung. It doesn't look like the ones we saw in school. I wouldn't even recognize it as a lung If I didn't know better. Interstitial Lung Disease. It is the thing I wished it wasn’t. There is no cure. For you, it is a death sentence. It occurs to me now That you were right to be afraid.

Earlier that day, Among your family, a fight broke out. Your husband was there (for the first time, For he fears hospitals)
And your son, and your two girls.
Your boy does not want you here
It became heated.
He was escorted out by security
Things are complicated now.
You are the heart and soul of the family
Your girls tell me
The family needs you.

To make things worse,
There had been talk of
Tracheostomy,
Of getting better after a few months.
Now I know
When you come off of the vent
It will be to take your final breaths.

I meet your husband.
He has tears in his eyes as he looks at you
He doesn't like all of the tubes.
Your eldest has to leave.
“Daddy hates it when we cry”
She tells me when I find her outside.
I know that there will be more tears.

The medicine team
Fixes your high sodium.
But, as they say, we are
“Rearranging deck chairs on the titanic”
We can fix your numbers
But it won't save you.
Nothing can save you.

I find the palliative team
We make a plan
For a family meeting
In the morning.

We find a quiet place
Meant for the delivery of bad news.
We speak with your daughters
Who have had so much hope
Who have been talking about
“When mom comes home”
I do not know if I am relieved
To see them finally realize
Or if I feel a terrible guilt
For shattering this future
They had built in their minds.

Your younger daughter asks,
“Are you telling me my mother is going to die?”
Yes.
And I see the moment she finally understands
Because she crumbles.
She has been so strong.
I have not seen her cry since we first met.
This time, it is not just tears.
It is sobs.
It is the sound of someone losing her mother.
I put a hand on her shoulder.
I don’t know what else to do.
Finally, she says she needs to be with you.
I stay with your oldest
Who was being strong for your younger.
She cries when we are alone.
She wants to protect her sister
But she doesn’t know how.

I come by your room.
You are peaceful.
They have upped your sedative, which I tell your daughter
She is glad of that. She wants you to be comfortable.
She shows me pictures of your family.
I listen to her talk about her cat, moving, hobbies,
And finally about you.
You are her best friend.
I leave you together.
She wants to tell you
What she now knows.

When I come by in the evening, you are alone.
They have gone home to break the news
To everyone else.
To gather the troops.
To say goodbye.
They know that you wouldn’t want to be kept alive
With no chance of recovery.

I hold your hand and greet you,
Though you do not respond.
I don’t know if you can hear me anymore
But I pretend that you can.
I tell you that I am leaving for the day.
I promise to come back.
On Monday morning, you don’t respond
When I say your name.
Today is the day. I tell you your family will be here soon.
I promise to come back.

When I come back
There are no more tubes.
Your family waves me in
As I hover by the door.

They are all here—your children, your husband, no
longer fighting one another
Here to say goodbye.
You are breathing on your own.
You look like a fish out of water.
Your Oxygen Saturation is 6%.

Your daughter grabs hold of me and cries when I walk in.
I help your son tape a cross to the palm of your hand.
His favorite cross. The one he keeps with him.
As your respirations grow shallow,
Your children all say that it is okay
That you can go
That they will be okay.
I see you take your last breath.

10:54:45.
Time of death.
I see the notification of “asystole” before the nurse comes in to check.
Your daughter weeps.
Long, terrible sobs.
The sobs of someone who
Has lost her best friend.
We all stand there.
For some time.
There are words about where you have gone,
To be with your mother, your father, and all of the family pets.

Slowly, your family leaves.
Until it is only her and I.
She grabs my hand
Her head on your chest
Her tears now quiet.
“She’s probably having margaritas
With her mom
Right now”
She says, her voice quivering.
I leave her there to say goodbye.
As she leaves, she thanks me
Pulls me into one last embrace

Stains my coat with her tears.
I tell her I am sorry for her loss.
"I hope the next time we meet, it’s at the grocery store,"
I say, a thing I tell all of my patients when they go.
She laughs and then cries again.
And then she leaves.

And now I feel untethered, with
No one left to comfort.
I go to your room
And I cry.
You are the first patient
That I have lost.
I am surprised by the sobs that escape from me
As I look at you.
Quiet.
Peaceful.
You don’t look scared anymore.

A nurse walks in.
“Your first?”
I nod.
She gives me a knowing look.
The ICU team I have gotten to know
Hugs me when I come out.
They say it is good
That I care
So much.

And I wonder.
If your kids are right.
I wonder
Where you have gone
What happens after we die
I wonder
If your family
Will pull through
In one piece.

I don’t know.
I can’t know.

But I do hope
That you get to have that margarita
With your mom.
An Emergency? | Martin A. Dufwenberg

I felt almost dirty going through my mental checklist, thinking back to all the signs and symptoms we had learned about in class. Menorrhagia. Dyspareunia. Cachexia. Anorexia. Pelvic pain. Foul smelling and plentiful vaginal discharge. History of HPV infection. Ms. G presented with a textbook case of cervical cancer, and I felt a perverse excitement when I was able to predict her every answer to my questions during her medical interview with me.

But then reality hit. Ms. G was an undocumented and impoverished 32-year-old woman with five children and had been diagnosed with cervical cancer two years ago. She had not received any treatment for her condition and had come to our free clinic to finally seek help. But what could we possibly do? Hospital admission with my local institution wasn’t an option as Ms. G was in the country illegally, so we would have to find a doctor in private practice who would be willing to treat Ms. G pro bono and a hospital willing to write-off the costs of hospitalization. And if we did find a doctor, what if Ms. G’s cancer had metastasized? What physician would be able and willing to subsidize chemotherapy over many years? Answering these questions gave me no comfort – was I helping patients or was I working in a Kafkaesque hell? It was hard to tell.

From early on in our medical education we are taught about the importance of the Emergency Medical Treatment & Labor Act (EMTALA). This piece of legislation requires that hospitals provide emergency care to all patients, regardless of ability to pay or their country of origin. And there arises an apparent paradox: emergency care for terminal cancer is readily denied, while emergency care for gunshot wounds and myocardial infarctions is promptly doled out without reservation. Indeed, in our law not all emergencies are created equal.

EMTALA arose as a response to “patient dumping” by hospitals, a deplorable practice where hospitals would refuse to treat indigent patients with acute and life-threatening conditions. Although well intentioned, continued
EMTALA inscribed to law the tragic decision that we should save from death those that we can see and that can make us uncomfortable, but neglect those that are invisible to society at large. We treat the man hemorrhaging after a gunshot wound, but we turn the cold shoulder to the mother with five children who is dying from cancer.

As medical professionals we need to advocate for a second-generation EMTALA, one that does not discriminate between emergencies merely based on optics. We need a law that recognizes that emergency care is not exclusive to that which arises in the emergency department, but also to chronic diseases like cancer. Perhaps then Ms. G could get the treatment that she deserves.

In a Greek tale, Sisyphus, the King of Ephyra, is sentenced to an eternity of unending frustration when he is forced to push a huge boulder endlessly up a hill. When I had left Ms. G’s exam room and saw her five children play in the clinic lobby my emotions must have been similar to that of Sisyphus: Powerlessness. Hopelessness. Anger. We often ask why medical students have higher rates of depression and suicide than the population at large, and answers typically revolve around the academic rigors of medical school. But what if it is the Sisyphean aspects of medicine that are the problem? Let’s change the system: empowering patients will empower us all.
3.5.19
"I don't write my own law."
- 65-year-old man with metastatic bladder cancer

3.7.19
"I just want to go home."
- Transitioning to end of life care

3.14.19
Memories of grandma's garden in Wisconsin.
An alcoholic father.
Her two dear fur babies.
- A patient's story

5.16.19
I never knew my grandmother.
I did not see her suffering, nor the manifestation of her disease.
But I saw the repercussions of her malignancy.
My father lost her so young, I saw the emotional impact it made.
That emotional impact leaving thumbprints on each generation.
Fast forward more than 50 years after her death, and I am here in clinic,
Sitting with the very women who suffer from the disease that took my late grandmother.
The scars on their chests are striking, I'm sure altering not just their bodies, but their spirits as well, perhaps
more than they ever imagined.
Some women are here for surveillance. Cancer free another year. A smile.
A small victory on a long journey, hoping their bodies stave off the return of the cancer.
Some women are here with complications, their disease spreading uncontrollably.
Their bones are breaking, their lungs are drowning, their organs are painfully growing, their spirits
becoming defeated.
As I examine them, talk to them, about the side effects of both their tumor and the chemotherapy, I think
back to my grandmother.
Did she suffer as they did? Did she have support as they did? What were her options?
How would her life be different had she had this disease now?
For her? For my dad? For me?
All that is left is a scar.
- A scar

5.30.19
"I don't even know ASL (American Sign Language!)"
- 63-year-old deaf woman with expressive aphasia
- A lesson in not judging a patient by their illness

6.12.19
"Sir, how do you think you are doing?"
Flat affect, eyes wide, thumb rolling. "I'm fine," he says.
Behind him, his wife is tearful, shakes her head violently from side to side.
The disease is changing him, and their marriage, quicker than she would have hoped.
- Parkinson's Clinic

6.28.19
First time in the OR today.
Lap chole, 75-year-old woman.

continued
Such an unnatural environment but thrilling at the same time.
It’s wild to be able to see the patient like that, both inside and out.
Vulnerable.

7.7.19
Lola, I’ll call you.
Presented with SBO incarceration into a ventral hernia.
From the ED consult to signing off, to reconsulting because you were getting sicker.
To consenting you for surgery to sending you off in preop. “My angel,” you told me.
To seeing the first incision, to helping close you up.
To walking into the waiting room of what looked like the entire family.
To sharing some good news, but also concerns for the future.
To hugging your daughter and sister.
I was there every step of the way. I felt like an active participant in your care.
“You learn the most from your patients,” they keep telling me.
Now I know why.

7.11.19
I saw death today.
Compressions after compressions, more despair.
Her lifeless arms flailing by her side,
Her chest bouncing up and down under my palms.
Blood pouring out of the chest tube; a crime scene if you saw it in a different context.
I didn’t know her. I couldn’t even tell you her name.
But I knew she was dead the moment I stepped up to do compressions on her.
Why did I volunteer for that?
I felt hypocritical just standing on the side, not jumping in eagerly like my other classmates.
Was I doing this just for the “educational opportunity”? For my own benefit?
20, 19, 18… my arms are burning but the adrenaline pushes me to keep going.
12, 11, 10… I can sense the hopelessness.
“Everyone, stop what you’re doing.” Family withdrew care.
I step off the stool and look at her.
Her eyelids are taped shut.
She turns cold, so much colder and faster than I could have imagined.
I peel off her pulse ox, almost expecting her hand to grasp mine.
The blood is swept clean, fresh blankets are laid on the bed, and I head home.
An unbelievably anticlimactic finish to one of the most traumatic experiences of my life.

7.13.19
8:00 pm. I’m half way done with my 28-hour trauma shift.
I’m scrubbing in for a surgery, yellow suds slathered on my arms and swirling down the drain of the sink.
Thunder crashes outside the window. It’s monsoon season in Tucson.
Lightning flashes and illuminates the OR hallway, which is completely empty tonight.
-A medical student’s Saturday night

8.5.19
“Can I listen to my heart?”
I hand him my stethoscope.
As the bell hits his small chest, his eyes slowly grow in amazement,
His mouth hits the floor.
“I hear it.”
- Pre-op in pediatric surgery
He must have weighed 400 pounds, and was sitting in a recliner chair when I first saw him. His nose was purple and swollen and he suffered from MRSA. Nurse Alice said, among other things, the super bug famous for boils, sores, and its stubborn resistance to antibiotics. Staff entering the room were required to don plastic gowns and surgical gloves to avoid being infected themselves which meant I would spend the next four hours sweating.

Is he allowed out of bed, I asked? The first of a series of questions I was required to ask about why I was there. Report they called it. He won't need to. He's got a Foley catheter for urination. She pointed at his right leg, which had been recently amputated, the stump still covered with bandages. Do not let him get up and do not let him pull anything out, she said referring to the oxygen cannula in his nose. His blood oxygen drops like a rock when he does. He pulled it out as she spoke, as if to demonstrate what she was

continued
saying, and she put it back in. Leave it alone! To me, she added, Do not let him hang his legs over the edge. He’s already slid out onto the floor and we had a hell of a time getting him up. She left. He wheezed.

He said nothing and began changing the television channels with the remote as though searching for a show that would take his mind off his misery, off his pain. On the wall, below the television, a pain chart indicated pain levels ranging from one to ten, with a little yellow face beneath each number. Below Number One, a bright yellow happy face smiled. Below Number Ten, though still bright yellow, the mouth had turned upside down and tears spraying off the head. I thought Number Ten ought to be purple, the way patients looked when they reached that state. Buddy looked like he was about a 9.5, about as much pain as you could bear without uninhibited sobbing.

He asked me if I wanted to watch the Yankees. Put them on, I answered. He resumed flipping through the channels and when he reached the Yankee Channel, kept on going, not leaving any one channel on for more than half a minute. Commercials played on most of the stations, imploring him to buy a new car, or how to be beautiful, or hawking prescription medications. Ask your doctor for a prescription today, and you too can lead an active laugh-filled life while you suffer through a debilitating illness. The ads didn’t show what people suffering from those illnesses really look like. In the ads, they were beautiful, smiling, happy.

I wish I could just fucking die, he said. I’m in so much pain. Why can’t they give me something to knock me out for 12 hours? They knocked me out for the operation; why can’t they do it now? I’m fucked. What difference can it possibly make? Why are they letting me suffer this way?

I could see Nurse Alice across the hall and signaled her to come in when she was available. She came in a few minutes later and promised to check his records to see when he was due for pain medication next.

Please. Please. Please. He told her. I’m in agony.

She left. He went back to changing channels and shifting in the chair trying to find a comfortable position.

I wish I would fucking die already, he said directly to me, lifting his gown to show me his scrotum which had swelled to a size of a cantaloupe and turned a sickly purple color. Look at this! Look! No matter what way I sit, it still hurts. He covered it up and squirmed in the chair, wincing every time he moved.

When the nurse comes back in, we’ll see what we can do to make you feel more comfortable.

He extended his arm to me, asking for help shifting in the chair. His purple DNR bracelet (Do Not Resuscitate) dominated my attention more than anything. I wondered if he would leave the hospital alive, and wondered too about the conversations that had already taken place before a bracelet like that was put on. But I didn’t need to know about that to prevent him from falling out of a chair, nor would I ask about it. If he wanted me to know, he’d tell me. I did get the sense Nurse Alice was reluctant to give him more pain medication, but didn’t really know that either, nor would I ask about it. But wondered if he was about to die anyway, what did it matter?

I stood up and moved next to the recliner, posturing myself to avoid wrecking my back, and extended my right arm, keeping it bent to work like a crane. He clenched his fingers around my hand and pulled, managing to shift in a forward direction, but also close to the point where he could slide out of the chair.

Not too far, I said, or you’ll end up on the floor. I withdrew my hand but he moved closer to the edge.

I gotta do something with my balls, he said. They’re killing me.

The nurse is across the hall, I said. She’ll be in when she’s done.

A half an hour went by. He kept wincing and saying he wished he was dead, and that was a flag, being a suicidal statement. Observers are instructed to share that information with the nurse, but according to the checklist the observers are required to mark every 15 minutes, he’s been saying that all along. The checklist indicated a continuum of moods beginning with aggressive and combative, and moving all the way to calm, and sleeping. There were other choices: agitated, climbing out of bed, confused, crying, fearful, hearing things, seeing things, pulling on medical equipment, restless, sad, statements of self-harm, suicidal statements, suspicious statements, tense, threatening statements, suspended
verbal abuse, calm, friendly, sleeping, and talkative. The last four items requiring only a checkmark on the sheet, but for all others the nurse was to be notified. No definitions for the terms were included with the sheet, or in the observer training, leaving many questions. What was the difference between agitation, restless, and tense? How different were suicidal statements from statements of self-harm?

The word calm might be the most deceiving term of all. Often patients were calm, but there were other times, when the word did little to describe their state, other than that it didn’t fall into any of the other categories, but they were anything but calm. Multiple words are necessary to describe those states. Silent might be a better term. How about enraged-silence? Or so-angry-they-are-unable-to-talk? Or ready-to-explode? Or thoroughly-discouraged? How about without-hope? Not that adding additional terms would matter. Any remarks by an observer, being unlicensed, have limited usefulness. Clinical notes are recorded by doctors, nurses, and social workers. Sitters, one-to-ones, however they are called, are not part of the decision-making process.

A doctor, one of the residents, came in, and asked Buddy how he was feeling.

I’m in fucking agony, he answered. Can you do something? Help me, please. Can you knock me out for 24 hours?

I can’t do that, not in your condition. He listened with his stethoscope, then lifted the blanket, pausing to look closely at the bloated scrotum and amputated leg. I’m going to double your pain medication; that will help.

Thank you, Doctor, but I wish you would knock me out. The doctor left.

Not long after that, Buddy tossed his blanket onto the floor and edged forward in the chair. Nurse Alice came back. I stood facing him, a hospital overbed table between us, serving as a railing to hold him in. The gown rode up his thighs, above his genitals, tightening against his giant belly, and exposing his leg stump and the engorged purple scrotum that looked bigger than it did before. Nurse Alice, at slightly more than one hundred pounds, standing to his right, would be no help lifting him as he inched forward into a position where he might slide out of the chair onto the floor. I moved the table up against his belly, placing my full weight behind it to prevent his slide. Nurse Alice put her hands on his right arm, asked him not to get up, and nudged him backward.

I’m in agony, he said. No matter what position I’m in, it hurts. Can’t you give me something? The doctor said I could have more. Please get it. It hurts so bad.

I can’t do anything until he writes the order, she answered. I have three other medications to give you in the meantime. I’ll be back. She turned to leave.

Kill me if you want to be useful. What the hell is that other stuff going to do for me?

She didn’t hear him. She had already disappeared up the hall. She returned shortly with another nurse. Each of them donning gowns and gloves. A Patient Care Tech wheeled an EZY-Lift into the room, a device used as a crane to lift patients while they are transferred to or from the bed. Good idea to use a lift, I thought. There was no way four people could lift this guy. He’d be safer in bed, the last slide convinced me of that. We made the transfer without a problem and they left the room.

The transfer did little to help his pain. He tossed and turned seeking relief from the pain. He mentioned wanting to die again, but making an entry in the Suicidal-Statement column seemed ridiculous. I calculated the number, at least 12 times already.

What’s taking so long with that pain medication? He asked.

She’s across the hall, doing something with that patient over there. I’ll signal her when she comes out, I answered. By then, two hours had passed since I first heard him ask. My mind jumped all over the place. I knew where she was, but I didn’t know how busy she was, or what kind of situation she faced with her other patients. Nor did I know Buddy’s history of medication requests. Had he asked for pain medication every 10 minutes for the last two weeks? Had he already reached the maximum amount? But none of these questions concerned me. I was there to make sure he didn’t end up on the floor.

His pain dredged up unsettling memories in me, of having part of my own foot amputated as a teenager, of blinding pain. They gave me medication. I don’t remember how much. Somehow it numbed continued
my ability to cry out more than it numbed the pain, 
or that was at least how I remembered it. Memory 
is so reliable, and the more I watched Buddy suffer, 
the more painful memories cascaded from the 
backrooms of my mind, memories of wounds, of pain 
beyond what I could bear, of asking the doctor to kill 
me, and what it’s like to mean that, and how foolish 
I felt afterwards for having asked the doctor to kill 
me. I wondered too if Buddy was experiencing that 
distortion of time that people withdrawing from drugs 
and alcohol do when minutes seem much longer, as 
though time is barely moving at all, or do they forget 
they just asked for medication? Or the pain just won’t 
quit and they can’t think of anything else?

We talked some. He wasn’t hostile, as people in 
pain can often be. He extended his right hand and 
I gripped it palm-to-palm. He used me for leverage 
while he sought a position that didn’t hurt.

Nurse Alice returned with three medications, 
none for pain, and scanned his identification 
bracelet three times, once for each medication. 
One of the supervisors had marveled recently 
how patient invoicing was now instantaneous. 
The patient would be invoiced for any and all 
medication the instant in time the wrist is scanned. This 
represented a big breakthrough in modern medicine 
in some minds. Florence Nightingale and Clara Barton, 
lacking MBAs, couldn’t run units in the more modern 
commercial-minded hospitals, and I thought about 
that as she scanned. Not that she should be blamed 
for replacing compassion with bar coding. None of 
these methods were Nurse Alice’s idea. It’s a business, 
not the Bible, and not even Mother Teresa could be a 
manager here.

Do you have the pain medication? He asked.

No, I’m sorry, she told him. These are...she named 
them, explained what they were for. I’m still waiting on 
the doctor’s order. I’ll bring it in as soon as he writes it. 
I’m sorry it’s taking so long.

He balked. His expression something like blank, 
but not really blank. Frozen in time? His psychic 
trajectory had slammed into an immovable object and 
now he just stared ahead blankly. An uncomfortable 
silence followed, interrupted only by Nurse Alice 
asking him if he would take the other medicines. He 
nodded. She gave them and left, back across the hall, 
where two other patients demanded her attention. The 
call bell was ringing above a room down the hall. If this 
were the army, she’d call it a cluster-fuck.

He took my hand once again and tried several 
positions in the bed trying to find one that felt tolerable, 
before closing his eyes. He looked like he wanted to 
sleep. I hoped he would. I stayed quiet. Ten minutes 
went by, and then I heard gurgling noises coming from 
under the blanket. A god-awful stench flooded the 
room. A minute after that he began to sob.

I just shit myself, he said. In a million years, I never 
dreamed I would end up this way.

Don’t beat yourself up, I told him. You’re in the 
hospital. We’ll get you cleaned up. Try to relax. I looked 
out the door but didn’t see anybody, so I pushed the 
call button. Can I help you? A voice asked from inside 
the wall. The patient needs a Tech for assistance. 
Please.

A tech showed up fairly quick to assess the 
situation. He’s too big for us to move. We need at least 
two more people, she said. I’ll go get what we need. I’ll 
be back. She left, but didn’t come back.

I wondered about stuffing a towel under him, 
something to keep him dry underneath, but even 
that would take more than one person, and I worried 
about disturbing his wounds too. I wiped his face with 
a wet cloth; that was all I could do. I thought that even 
if I do nothing for his pain, maybe I could distract him 
with conversation. At least he’d be thinking about 
something else.

It’s too bad pain can’t be shared like other things 
can, I said. Like work or responsibility. I paused 
before continuing, to make sure he didn’t interpret 
what I was saying in a way I didn’t expect, but he 
just looked at me silently waiting for me to go on. It’s 
too bad we can’t share the load, five percent to one 
person, and five percent to somebody else, break it 
up. Something like that.

Just for five minutes, he said, stopping without 
saying anything else.

Five minutes? I asked. You’d only stop the pain 
for five minutes?

Yes, five minutes, he answered. Then she would 
understand what I feel.

I was thinking about sharing a burden, among a 
group, I said.
I couldn’t in good conscious want anyone else to experience this. Just long enough for her to understand how much it fucking hurts.

He extended his hand again. I stood up and extended my right hand, used my left hand for extra support, and leaned backward to avoid being pulled onto the bed. He tried several more positions seeking relief. I wondered how much the mess beneath him fueled his restlessness.

The talk about pain showed he could be distracted, even if for just a short time. The television had been chattering away since I came in. White noise to drown out blinding pain, but too loud, even for me. I didn’t know if he had turned it on or someone else. Maybe the sitter before me. Dr. Phil was on. Buddy didn’t look like a Dr.-Phil-kind-of-guy. I asked him if he would lower it. He did and went back to flipping through the channels, looking for that one which would take his mind off his misery.

Somebody was shouting across the hall. The privacy curtain blocked view from outside the room, but the voice came through loud and clear, an elderly male voice. Where is my tool box? I want it back and I want it back now!

I’m sure your tools are home, Bob. Nurse Alice talking. You’re in the hospital. Everything is alright.

Who the fuck are you? He shouted. How did you even get in here? Somebody call the cops.

Two Patient Care Techs went in, young, barely out of high school, and tried to calm him down. Nurse Alice came out from behind the curtain, and went down the hall to answer the call bell there. I wondered how they would handle that guy across the hall. A shot in the arm? Assign a One-to-One? Somebody turned the television on.

I thought about all the people who experience the last days of their lives in a state of paralytic sedation propped up in front of a television screen watching commercials for 24 minutes of each hour, 60 minutes if the shopping channel is on. The end being a series of film grabs and chatter, little of it connected, something like a slide show of random images and voices telling them they just don’t measure up to others, they’re not as beautiful as the others, the way they should smell and look and where to find the very best healthcare experience. All of that coming as the last of their reasoning and language ability capacity collapses.

I looked out the window at the people coming and going in the parking lot below. The stench from the bed overpowered everything else, and I wondered what happened to the promise of getting him cleaned up right away. By then, he’d feel the corrosive action on his skin by the puddle of black slime he was laying in. He kept moving around in the bed smearing the mess onto the Ezy-Lift sling, and flipping through the channels. He paused at the Golf Channel, the NFL Channel, the MLB Channel, baseball highlights, a replay of the 1969 World Series, the Real Housewives of New Jersey, a Lexus commercial, and on to the next, not watching any one channel for more than a minute.

Outside, the world was clear and bright, and judging by the way people were dressed, summer-like, the first really nice day after a long rainy spell. It would be nice to open the window, to watch the breeze lift the shade away from the glass and feel the warm breeze, but the window was permanently bolted closed as though there was some sound reason to separate patients from fresh air. Safety? Staffing? Who knows? The nearest door that opened to fresh air was several hundred feet away. We were, in essence, in a man-made cave, flooded with artificial light, breathing recycled air. Kenneth Burke was right: We humans have separated ourselves from our natural state with instruments of our own making.

I moved to the door to look for the nurse or tech. A different tech approached, on her way to the linen cart. She stopped about 15 feet from me, scanning the hallway, with a puzzled look. She was 20 feet from Buddy, but couldn’t see him from where she was standing. Is that smell coming from in there? She asked, pointing to the room behind me.

I shook my head, yes. I’d clean him up myself, but it’s gonna take at least three more people.

She rolled her eyes. It’s crazy today. We’ll be in as soon as we can.

By then, Buddy had been waiting two and a half hours for pain medication and, an hour to be cleaned. The patient behind the curtain across the hall began shouting again, demanding to know who the hell took the ladder. From what I could guess, something about the hospital room dredged up memory fragments of Buddry’s Blues | Phil Nerges continued
construction work long ago and he was trying to make sense of the present by comparing two moments in distant time, without the benefit of anything in between. Nurse Alice ran back into the room and disappeared behind the curtain.

Mr. Jones! Please sit down, she told him.

Who the fuck are you? he demanded, in a tone suggesting he was near becoming violent.

I’m your nurse, she went on. If you don’t sit down you are going to fall again.

I never fell, he answered. You don’t know what you’re talking about.

Please, Mr. Jones, you are in the hospital, she went on. You’re going to have to trust me. She sounded sincere enough to place him in a state of utter confusion while he wondered: What if she was telling the truth? Then, how did he get here? She reappeared from behind the curtain, and I signaled her to come over.

Any luck? I asked. This guy’s in agony.

She stepped next to his bed. I’m so sorry. Your medication hasn’t come from the pharmacy yet. I’ll be back as soon as it does.

He groaned, making an expression I couldn’t interpret, and then turned his gaze toward the window.

On her way out, she informed me that she had six patients, and only one of them was oriented, meaning that Buddy was the only one who knew who and where he was. I wasn’t sure what to do with that information other than to encourage him to wait a little longer, as though he had a choice. I wondered what it would be like to be in pain like Buddy, and not know who and where I was. To be in a world of strangers. I wondered too, if he were more aggressive, or if he began yelling so loud that he could be heard at the far end of the unit, whether that would make much difference. It has been done.

Buddy went back to flipping through the television channels, stopping at a baseball game.

Baseball fan? I asked.

Yes, he answered.

Yankees or Mets?

Yankees.

They’re on now, I said. They started at four today.

He turned the Yankee game on, and we talked about the injuries they had suffered this year, and how they still managed to be playing good ball. It must have occurred to him that discussing baseball injuries, after just having his leg chopped off, was ridiculous. He laid back and stared at the ceiling before turning once again toward the window, and for a moment appeared to be asleep. I turned the sound down to a level barely audible, hoping he would find relief as he slept. He tossed and turned for the next half hour, occasionally looking up to see the score. I stared at the silent television screen. He didn’t care about the sound either.

Help me, he said, extending his hand again. Come around to the window side.

From the window side, I locked palms with him, gripping behind his elbow with my other hand for extra support. He shifted toward the foot of the bed and came up into a sitting position, before hooking one leg over the side, but coming precariously close to the edge. He wanted to sit on the edge of the bed, hoping to find a position that didn’t hurt. If he inched too far. I wouldn’t be able to stop him from sliding onto the floor.

You can’t do that, I said. The nurse wants you to stay up in the bed.

With my assistance, and his left hand, he shifted back, then let go of my hand. He looked at me from a sitting position for what seemed like a long time. He looked completely disgusted, but said nothing. Then he closed his eyes and dropped backward onto the pillow, slightly cockeyed in the bed. I expected some form of rage but he kept quiet. I turned my chair toward the television to create the effect of sitting side by side, occasionally glancing sideways to make sure he wasn’t yanking on any of the various tubes connected to him.

The Yankees loaded the bases and followed that with a grand slam, now taking the lead. I looked to see his reaction. He’d finally fallen asleep. I pushed the call bell button again and again with no response. I wondered what effect that mess beneath him was having on his skin. What a stink! I turned back to the Yankee game. They had brought in their relievers...
and I let my attention lock on the game and all the commercials that come with it. Everybody looks so happy on television. The game ended and I looked to see his reaction. He slept through it.

I turned the chair again, facing him now. He wasn’t moving except for an occasional twitch. I wondered if he had made enemies with the staff and whether that had anything to do with their inattention. I looked closer. No movement. I debated whether to check his pulse but I looked out the door and signaled a tech to come in, telling him I didn’t think the patient was breathing. After checking his pulse, he agreed. Buddy was now turning purple. The room filled with medical staff wearing plastic gowns, Nurse Alice, the charge nurse, the unit supervisor, two doctors, cardiac and respiratory techs, and two Personal Care Techs. I stepped back into the corner, while they discussed what was to be done. Buddy was a Do-Not-Resuscitate, so his life would end now. He had no visitors in the two weeks he’d been there. There was a disabled sister who lived far away. She wouldn’t be able to come.

I experienced a sense of deja vu that we were standing next to a corpse in the same way that groups have stood around corpses for as long as people have been dying. Modern medical chatter has submerged the superstitions of antiquity, yet it’s fair to speculate this group subconsciously pondered the belief that Buddy’s soul was still invisibly present in the room, watching us, and now the doctors and nurses were all very nice. In Buddy, we feared our own destiny. He would be washed and anointed and clothed in clean garments, according to the ancient traditions.

I stepped up to the bed and patted him on the shoulder. Later Buddy, I said. I’ll see you on the other side. A couple of them glanced at me for a moment, but they remained absorbed in what needed to be done. I felt almost as if I were the ghost and they didn’t see me at all.

Nurse Alice stood on the other side of the bed wearing an expression that was hard to read, other than looking ill-at-ease. I wondered if she was thinking about Buddy’s pain medication, and right then the guy behind the curtain across the hall began yelling again.

I stepped out of the room, peeling off the gown, my shirt soaked with sweat. A security guard stood there as part of the Rapid Response Team.
Silent, his eyes speak
Wounds too deep, they do not heal
Hope for better days

She went in the night
And did not tell him goodbye
A husband distraught

Once refused to stand
Now proud to stride as we cheer
Joy is evident

A dark character
Harms himself, motives unknown
Back to jail he goes

A fixer he was,
Traveling the world in style
While dodging bullets

Cancer stole her voice
So she smiles, she writes, she nods
As I talk too much

Young and athletic
But cocci brought him bad luck
He stays strong for mom

Started as a zit
Of course, we cut and drained it
I’d be grumpy too

Reminds me of mom
Vegan, in shape, still she stroked
Determined to heal

Young mind, old body
Full of wonderful stories
In need of an ear

Quiet little boy
How did you hurt yourself so?
Mysterious truth

Anger and violence
In response to my questions
Curse you, dementia!

continued
Gentle, kind old man
Who is our president?
“Short, dumb guy,” you say.

Your mind is tied down
But when I requested art,
It took flight once more

Unable to move
Still he’s handcuffed and chained down
Wonder what he’s done

At her name you smiled
Her message got through to you
Though she’s far away

Married just a year
They weren’t expecting that
How long does she have?

Lung recovering
Breaking free from addiction
Breathe, heal, keep fighting

She opens her eyes
But does she really see me?
Obesity kills

His wife has cancer
So he must be strong for her
Response is denial

Has hair loss above
Too much hair in the wrong place
What patience she has!

With tears in his eyes
He asks brother, “Will I die?”
“You’ll be fine,” he lies.

Great news! Cancer free!
He looks up, unbelieving
Now he has to eat.
I exhaled a quick, “Ok,” as we sped down the stairs, grateful to have a resident who cared to guide me. We got to the trauma bay and there was silence. The patient hadn’t arrived, but several teams were ready. A quick scan of the covered bodies and masked faces told me I needed contact precautions. Hurriedly tying a yellow paper gown around me with shaking hands, I heard a voice announce, “They’re here.”

“19-year-old male with a knife wound to the right thorax,” said the EMT, out of breath. I didn’t hear much more after that. In my eagerness to be a useful medical student, I inserted myself into the organized chaos of the trauma bay in the only space left: the feet. I removed a pair of Air Jordan IX’s and threw them under the table. I pulled off a pair of black socks and froze. Under the black socks were a pair of clean, milk-white feet. But milk is a form of sustenance, a liquid with a life. These feet were the white of absence. The white of loss.

I slide my trauma shears up the side of his jeans and wondered why this man’s chest was being opened. Did they see his feet? It dawned on me that my gloves, gown, and mask were as clean as they were minutes before. There was no blood. If this man’s feet weren’t being perfused and there wasn’t any apparent blood loss, then where was the blood?

My classmates who completed their trauma service before me described the waterfall of blood that poured out during a thoracotomy, an emergent last-resort surgical procedure that has an overall survival rate of about 7%. But as this man’s chest wall was opened, I saw the most beautiful, silver pink lung. My resident asked me if I wanted “to try,” and I understood that if I was getting an opportunity to perform cardiac massage, then the patient was already gone. Squeezing a vibrating heart running on residual circuitry in the wake of its host’s departure, I saw a thick, black winter coat tossed on top of the man’s sliced clothes. My jumbled clinical knowledge began to organize itself and the implication of the chalky feet emerged.

Time of death was called and a moment of silence held for a life lost before we had a chance to help him. I left the trauma bay with my team of surgeons, understanding that our moment of silence would be held for much longer. Later, a young intern would ask me, “Was that the first dead body you’ve ever seen?” and I would shake my head no. What I didn’t tell him was that it was the first death to impact my approach to clinical medicine and to teach me how to think like a doctor.

I want to climb into the photograph, lift the gowned girl to my heart, her twig arms encircling my neck, half moons of fingernails digging in, pixie-brown irises pleading. I would smooth her forehead and she could let go of the wheezy-squeezey teddy, useless in plastic pink. It will be over soon.

I want to assure her. When you come out, you can tell me about all the scary things, but she cannot hear my voice.
Echo | Mark R. Abrams

Before I left the room,
I spread the blanket on your bed,
Because medicine isn’t just deciding what goes into your IV.
Pretty women wonder where my secret lies.
Overachieving medical students wonder where my secret lies.
I’m not cute or built to suit a fashion model’s size
I’m not smart or fit to be a neurosurgeon
But when I start to tell them,
But when I start to tell them,
They think I’m telling lies.
They think I’m telling lies.
I say,
I say,
It’s in the reach of my arms,
It’s in the reach of my experience,
The span of my hips,
The span of my knowledge,
The stride of my step,
The stride of my step,
The curl of my lips.
The curl of my curiosity.
I’m a woman
I’m a medical student
Phenomenally.
Phenomenally.
Phenomenal woman,
Phenomenal medical student,
That’s me.
That’s me?

I walk into a room
I walk into the clinic
Just as cool as you please,
Just as cool as you please,
And to a man,
Like an attending,
The fellows stand or
The fellows stand or
Fall down on their knees.
Fall down on their knees.
Then they swarm around me,
Then they swarm around me,
A hive of honey bees.
A hive of honey bees.
I say,
I say,
It’s the fire in my eyes,
It’s the astute observation in my eyes,
And the flash of my teeth,
And the empathy in my smile,
The swing in my waist,
The swing of my stethoscope,
And the joy in my feet.
And the utter joy in my feet.
I’m a woman
I’m a medical student
Phenomenally.
Phenomenally...Hmm.
Phenomenal woman,
Phenomenal Medical Student,
That’s me.
That’s me, I guess...

continued
Men themselves have wondered
Residents themselves have wondered
What they see in me.
What they see in me.
They try so much
They try so much
But they can’t touch
But they can’t touch
My inner mystery.
My inner mystery.
When I try to show them,
When I try to show them
They say they still can’t see.
They say they still can’t see.
I say,
I say,
It’s in the arch of my back,
It’s in the arc of my Achilles,
The sun of my smile,
The sincerity of my smile,
The ride of my breasts,
The rift of my differentials,
The grace of my style.
The grace in my physical exams.
I’m a woman
I’m a medical student
Phenomenally.
Phenomenally.
Phenomenal woman,
Phenomenal medical student,
That’s me.
That’s me!

Now you understand
Now you understand
Just why my head’s not bowed.
Just why my head’s not bowed.
I don’t shout or jump about
I don’t shout or jump about
Or have to talk real loud.
Or have to talk real loud.
When you see me passing
When you see me passing
It ought to make you proud.
It ought to make you proud.
I say,
I say,
It’s in the click of my heels,
It’s in the click of my Danskos,
The bend of my hair,
The bend of my pen,
The palm of my hand,
The precision of my percussion,
The need for my care.
The need for an accurate diagnosis.

‘Cause I’m a woman
‘Cause I’m a medical student
Phenomenally.
Phenomenally.
Phenomenal woman,
Phenomenal medical student,
That’s me.
That’s...me.
Desert Symbiosis | Jenna Kay
Do you know there’s a halfway world between each ending and each new beginning? It’s called the hurting time. (Nina George: The Little Paris Bookshop)

The night before below-zero weather is predicted to arrive, you stand in the driveway sobbing over a quart of dry gas, an additive that should keep the car’s gas line from freezing. Hysterical with worry that the car will not start in the deep cold, you view the dry gas as some charmed potion that will get you to work. But the metal valve that will allow the dry gas into the tank refuses to open—not when poked with the head of the dry gas bottle, not with the handle of a wooden spoon, not with anything you can think of to push it with. How is this possible? The valve opens perfectly well when you pump gas.

Your brother calls in the midst of your hysteria. He suggests everything you already did. You text your college roommate, whose husband is a retired police officer. He’ll know, you think. His suggestions match your brother’s. You desperately want to turn to your husband Tom and say, “Honey, I may have to take your car in the morning.” Instead, quivering from worry and out of options, you determine that if the car won’t start in the morning, you’ll call the dealership. They’ll take care of it. After all, they came to the house nine months ago, after Tom died, to make an offer on his car. They’ve known you for years and, empathizing with your sudden aloneness, have offered to help anytime.

Later that evening, when you are calmer, you check online. You learn that Ford hides a tiny funnel, the perfect size to fit into the gas tank, in a small hatch in the back of the car. Like magic, the tiny funnel opens the metal valve; you pour the dry gas in, satisfied that you’ve done all you can to make the car start the next morning.

Intellectually, you know the problem is neither the dry gas nor the cold. But the heart operates separately. The real problem is your aching aloneness. Tom wouldn’t have known about the secret funnel either, but his presence would somehow have prevented worry about plunging temperatures. His absence creates its own kind of cold—a numbing, constant ache.

Joan Didion confirms for you that emotions hijack logic. Writing about the sudden death of her husband, she notes, “There had been occasions on which I was incapable of thinking rationally.” She would have understood the dry gas hysteria. So would psychologist Rebecca Miles who notes that “cognitive functions (concentration and focus) are profoundly altered” by grieving.

You have known that since Tom’s death, you are going through your days on foggy auto-pilot. Even so, you are unprepared for the accidents. The first one happens three weeks after you bury him.

On a Sunday evening after a busy day, the emptiness in the house overpowers you. You grab a dust cloth. Inattentive, sniffing, moving through a blur of tears, you trip over the edge of Tom’s guitar case, still in its place in the living room. You crash down hard on your left shoulder. Searing, burning, knifelike—all those words you use for sudden, intense pain—are inadequate. Thoughts swirl: I’m on my left side with a left shoulder I can’t put pressure on. How am I going to get up? If I get up, can I drive myself to the emergency room? How will I get help? Where’s the cell phone? How did this even happen? I knew the guitar case was there.

And then anger flashes: I hate the guitar I hate the guitar. No, I hate HIM for not being here. I hate him for leaving me. He should be here he should be here. Not just his guitar. HIM.

The intensity of the fury focused on Tom shocks you. Feeling guilty, you turn it back on yourself. I have to take care of this. I can’t keep asking people for things. The neighbors will be sick of me.

Minutes pass. Pain ebbs. Both cats sit nearby, placidly blinking at you. You manage to get yourself up. Some reduced range of motion, but the left arm works - mostly. No dislocation. No need for emergency treatment. You go in to teach the next day and treat your arm tenderly for a while.

continued
A few weeks later, however, your yoga teacher refuses to show you moves to strengthen that shoulder. “It’s been hurting too long,” she says. “Go see a doctor.” You begin physical therapy.

Then one night, when you respond to a crazy urge to test your new motion sensor flood lights, the second accident occurs. You miss the bottom back porch step, plunge into a bed of bellflowers, and twist your ankle. At physical therapy for your shoulder, you begin to cry as you explain this new clumsiness—recently deceased spouse, miscalculating the step. The therapist proceeds to treat your ankle as well as your shoulder and nods. “That happens,” he says. “It’s not just you.”

Sonya Huber, in “The Alphabet of Pain,” strikes at the heart of your experience. “Pain is the essence of out of control.” Your world has gone berserk. Without Tom, nothing is normal anymore. Choosing a tombstone, bursting into tears when you walk into a favorite restaurant, Tom’s beloved cat Fiona acting sick even though the vet repeatedly says she is all right. Your shoulder and ankle. Aching, so much aching. Emotional pain, physical pain; they wind around one another. You read Diane Ackerman’s A Brief History of the Senses and nod knowingly at this line: “Pain is as much an emotional and psychological affliction as a physical one.”

Habits die hard, though. Competence and dependability are your trademarks. You always meet deadlines. You are always “the prepared one” in classes, at meetings. Even as a new widow, you wage war on any appearance of neediness. After Tom’s passing, you miss only two teaching days. You go to class dressed like the teacher your students know, and talk like her. Your students tell you that you’re brave. You meet friends at restaurants and movies and baseball games. They, too, comment on how brave you are.

There is so much they don’t know. Makeup covers the eczema that’s developed under your eyes from crying every night. Xanax, bootlegged from relatives, induces the only sleep you get. You regularly crouch beside the sweater chest, lift the lid, and breathe deep, just to inhale the scent of Tom’s cologne lingering in the wool. The collected you that presents herself to the world is a fraud. The inner you shivers and cowers.

So you should have seen it coming, should have expected that your inner and outer worlds couldn’t clash so much without consequence. Over years of teaching, you have seen your undergraduates get sicker and sicker as the demands of a semester build. They cough and sniffle through class. They email about staying in bed or going to the health center. Why would you be any different? Just because you’re not getting colds as often as the students doesn’t mean your body isn’t reacting to stress.

“Stress itself is a trigger that affects multiple body systems, weakens immune functioning and can contribute to the inflammation that manifests as pain,” notes Suzanne Wright in Arthritis Today. She follows this information from a JAMA article with rheumatologist Dr. Wael Jarjour’s assessment: “Stress induces a pro-inflammatory immune response that can exacerbate autoimmune diseases.” How is it possible to be under this much stress and not know it?

But you are. You have been repeatedly assaulted by stress: faking that you’re coping well; removing Tom’s name from the title on the car; facing an intimidating stack of papers to grade when concentration is difficult; providing a death certificate so that Comcast will speak to you when you call them; deciding on repairs and maintenance to the house; writing a new will; sitting to eat dinner for one; learning how to live a life alone after 37 married years. There are bound to be effects from the cortisol dumped into your bloodstream over and over again.

Liz Rosenberg, writing in the New York Times about recovering from her husband’s death, notes the time when his lingering presence had finally moved out of reach: “I felt this viscerally. And my body responded: I immediately came down with pneumonia.” You don’t come down with pneumonia, but two years after Tom died, you enter a world of sharp, unrelenting physical pain. You don’t know yet that rheumatoid arthritis is tearing at your joints. That diagnosis will come, though, within a week of the second anniversary of his death. “Many rheumatoid arthritis patients are able to point to a stressful or traumatic event that occurred just before continued
the onset of their RA,” Carol Eustice reports in Everyday Health. The first rheumatologist, your PCP, and rheumatologist #2 all indicate that the stress of Tom’s death could have triggered the RA.

When it begins, all you know is how much you hurt. The pain starts in January with knees so tender you gasp each time you stand up. The stairs in your split-entry home become Everest, summitted only by stepping up with the right foot and meeting it with the left on the same riser, one step at a time. Then, in early February, your right hip gives out. You can barely hold yourself upright. Astonished at this new pain and limitation which, like the knees, comes on with no warning, you call in sick for the first time since Tom died. A week later, your right hand swells up so painfully that you can’t grip the steering wheel. This cascade of pain is too much to be coincidental. Blood tests are ordered and appointments with specialists scheduled.

As the second winter after Tom’s death grows on, you learn that pain is exhausting. Your night class that semester becomes a special kind of torture. During class, students’ energy buoys everyone. Still, they notice how gingerly you sit down, how little you move once seated. A student watches you limp down the hall and sends you off into the night with this comment: “You look worse every time I see you.”

You dread the post-class trek across campus in icy darkness to the parking garage. Bitter cold makes plumes of your breath. The five stairs from the classroom building down to the sidewalk demand careful scrutiny for unshoveled snow or slick spots. In baby steps while your knees scream, you hobble toward your car. The three blocks stretch like miles. Sometimes you cut through the campus Starbucks simply to feel some warmth before the last stretch. Wind lances through that last open space. The Arctic cold, the dark, the pain are endless. Often, on what is usually a busy footpath, no one else passes by. The emptiness of the campus at 8:30 p.m. exacerbates the cold, exacerbates your fear about how you will manage the staircase at your house.

As you drive home, you ache for Tom’s presence. When you had emergency gall bladder surgery six years before he died, you awoke to find a rose on the bedside table. For your outpatient procedure, only weeks before his funeral, you felt safe as he maneuvered the car through a snowstorm in order to reach the hospital by the designated 5:30 a.m. reporting time. Were he present on this bitter cold night, he would already have descended the steep driveway to bring in the mail. He would have fed the cats and cleaned their litter boxes. When you reached home, he would have enveloped you in a warm hug and carried your backpack up the stairs. But you’re on your own now, to manage the tiredness, the shrieking knees, the aching wrists in the face of routine household responsibilities. You miss him so much and you hurt so much that you cry as you trudge up the stairs.

Deep in your bones, deep in your primitive brain, you feel grief and pain and fear melding together, forming some kind of internal predator, all teeth and claws. But you have not yet read that this dark trio do, indeed, intertwine. Later, your doctors explain how stress morphs into physical pain. Later you find material from the American Psychological Association that explains how the pain of rheumatoid arthritis, an autoimmune disease for which there is no cure, feeds back into new sorrow: “Grief is another common reaction to chronic illness.” Sherman Alexie has called it in You Don’t Have to Say You Love Me: Grief. Repeat. Grief. Repeat.

Then the third iteration of the trio, fear, layers in. C. S. Lewis, struggling with the death of his wife, states, “No one told me that grief felt so like fear…. like suspense. Or like waiting; just hanging about waiting for something to happen.” Grief—over losing Tom, over losing yourself to a body that no longer operates reliably—generates its own world of fear. Tom should be here if you collapse in the shower or fall on the stairs. He should be here to help with elderly cats in need of medications and sudden trips to the vet. But he’s not here. You feel abandoned and alone. Ordinary, comforting things become out of reach. You stop buying Pepsi in the small bottles you favor; your wrists and fingers hurt too much to twist them open. A friend comes over to help change your sheets because your hands are too sore to pull a fitted sheet tight.

Aching | Helen Collins Sitler continued
The same darkness, the same fear, the same aloneness as when Tom died engulfs you, this time over losing the person who was just beginning to find her way as a widow.

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How do you adjust to the aching? To the pains, emotional and physical, that sap your life force? After the funeral, after the casseroles and visits to check on you have stopped, when your knees hurt so much you dread walking up the stairs in your home, what keeps you from simply going numb?

In looking back, you recognize that one critical factor is work. You return to your classroom the week after the funeral. Like Sheryl Sandberg, who describes her husband’s sudden death in her book *Option B*, you find work to be a normalizing space. You feel competent and secure; you know how to help a student teacher improve a lesson plan, what to say to a struggling Research Writing student whose paper sounds stiff and forced. Even though grading end-of-semester projects wears you out, the task blankets you in familiarity when nothing at home does. Later, when rheumatoid pain sears your joints, the classroom is still a refuge. You move around the room less than before, you type when your hand hurts too much to hold a pen, but you thrive on the vitality of your students. You are grateful not to be retired.

Two cats also force you to attend to needs outside yourself. Tom’s beloved Fiona and Meg, your personal shadow, sat vigil at the top of the stairs as EMTs carried Tom to the ambulance on the day he died. Unusually still, they knew something was amiss. Now both sense the change in the house. Meg hugs closer than ever. Fiona, stand-offish after her special human left her and never came back, demands extra petting and cuddling. You say goodbye to them out loud as you leave for work each morning and call their names when you arrive home. Meg invariably runs to the door to greet you; Fiona often awaits at the top of the stairs. These two warm, loving creatures lift your spirits. With their body warmth on your lap and mashed against you at night, they become furry heating pads for aching joints. Their purring soothes you.

You discover that some idiosyncratic habits you develop serve to heal the emotional aching. Emily Esfahani Smith, writing for *The Atlantic*, highlights research by Norton and Gino regarding the importance of personal rituals in grieving. The researchers discovered that “many people [in their study] reported private, personal, and emotionally-moving rituals that connected them to the memory of their lost loved ones in a deep and powerful way.” Doing so was a mechanism for exerting control in “the turbulence and chaos that follows loss.”

A friend has given you a journal. You begin writing letters to Tom. Over time, you fill five journals with minutiae of everyday life: “Meg dragged the plastic ring from a bottle cap out into the hall today. We played fetch for a while”; “Had dinner with Dave and Jane on Friday. Dave fell and broke his arm while [traveling in Italy]”; “Gaelic Storm [musical group] did that funny song again, about punching Russell Crowe in the head.”

And you fill pages with your version of a primal scream: “I never knew how much I depended on a hug from you, a simple touch”; “Your phone number is out of service as of yesterday. No more calls to you on my way home from work. I did that some days, honey, just to hear your voicemail announcement”; “I can feel the left finger hurting a little, the left wrist. Right hip is tight. Left knee swelling. It’s happening again. By the end of the week will I be calling Dr. T. again? It’s a different kind of grieving, honey. I was just beginning to figure out who I am without you. Now I’m being attacked by my own body.”

Words by poet E.E. Cummings also develop into a personal ritual. You keep tiny copies, three inches by three inches, of “I carry your heart in my wallet” in places Tom would love. You wedge one of these miniatures—“I carry your heart with me (I carry it in my heart) I am never without it (anywhere I go you go, my dear)—behind a large sign in Denali National Park. You stash another under a bus stop bench outside a museum in Anchorage. You leave one behind in a hotel room drawer in Dublin—“you are whatever a moon has always meant/and whatever a sun will always sing.” In Harry Potter World you toss one under a hedgerow. You visit these places wishing Tom were there, even as you know he would say, “Go. Enjoy. Live.”

continued
At Longwood Gardens, where you and Tom had gone on a whim for your January birthday, you drop a copy into a planter outside the Conservatory: “this is the wonder that’s keeping the stars apart/i carry your heart (I carry it in my heart).” You didn’t know as you celebrated your 60th birthday that the photos you took of Tom in the Conservatory would record the last of your birthdays that he would be with you. This poem, dropped in one of the last special places you shared together, connects you to him again, signals to him that, while you might sometimes be sad, you are out engaging with the world.

Over time you write fewer letters to Tom and place fewer poems. To keep him with you, you almost always wear a piece of jewelry he gave you—the opal ring, silver Navajo earrings—or the necklace a friend gave you after he died, of paper beads made from a photograph of him. And the poem. You carry one in your wallet, always.

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Outside your bedroom, the chime sent by a friend when Tom died dances in the wind. You smile; it’s as if he’s talking to you. As the chime sings, you pull corners of a fitted sheet snugly over the mattress. The washer buzzes. You run downstairs to throw towels into the dryer and start the wash load of sheets. Medicine for rheumatoid arthritis is like a miracle. Your pain is now well-controlled.

As usual, you spent this past Easter with Tom’s family, the seventh Easter without him. For the second year, you have not worn a wedding ring. The need to wear it every day has diminished. Now it nestles in the ring box Tom gave you over 40 years ago, beside his wedding band.

You try to honor the fullness of Tom’s memory by seeking out new adventures and new challenges. You know he would want you to. And physically you are once again able. Still, you guard your heart. Lewis describes grief as a winding valley that one traverses. New vistas open, yet sometimes “you are presented with exactly the same sort of country you thought you had left behind miles ago.” Tom’s absence is miles back, but when the ache of loss swoops in sharp and strong, you tell yourself that you cannot ever go through such emotional wounding again. Maybe some day your heart will be as open to new journeys as your physical self is.

But not yet.
she said,
hold it tight
through the brambles
the brier
the pine forest
take my hand
and don’t let go
take my hand,
she said,
so I did
held on
that night in ICU
held on
the best I could.
Tea and toast in the morning. Above the sink happy geraniums. Her last good friends.

His last year they stood together. He dried the plates and the glasses she passed him.

There was a dishwasher, but why bother when the beautiful red flowers stood waiting to be admired. When there was someone to stand alongside her.

It had rained overnight. The green backyard glistened. Happy red petals in the foreground warmed her.

Once, twice, he wrapped his arm around her waist as if to say hello. As if to say goodbye. Both

Remains | Philip Dean Brown
It isn't that bad here.
You talk to me even though I can't respond.
It's not that I don't want to, but this tube and sedation makes it difficult.
I enjoy seeing your team in the morning, as you discuss a way for me to get out.

I'm glad that I'm here.

Every day you come in and listen to me – put your hands on me.
You talk to me, acknowledge I exist.
It's nice that you make the effort.

I'm glad you know that I'm here.

Though as the weeks crawl on, I'm less optimistic.
You talk more about me, but less to me.
I see you outside my door. There are more of you now than before, yet no one talks to me.

Do you know I'm still here?

Of course I can't talk to you. You know, with this damned tube in my throat.
You poke and prod and discuss what to do with me.
My family is long gone, but not me.

In case you forgot, I'm still here!

Tonight the alarms are more obnoxious than usual.
You seem concerned about the numbers and lights, but perhaps less so about me.
Suddenly I am surrounded, maybe a dozen of you.
I don't think you knew, and I guess I can't blame you.

But even at the end, I was still there.
Healthcare Disparities: A Short Story | L.D. Camacho

Two things were made evident to me during my family medicine rotation at El Rio: the first is that healthcare disparities are undeniably present in Tucson and the second is that you never call a Hispanic woman less than 35 years old a “señora”, calling them “señorita” will do. The story of a patient of mine unfortunately exemplifies a common theme of healthcare disparities.

It was one o’clock and I had just finished my heavy lunch of a granola bar and water when I returned to the clinic. The morning was busy, I saw six patients. I looked at the afternoon schedule and it was clear that today would be merciless. My attending saw me and asked if I wanted to see a man with a PMH of HTN coming in for F/U after suffering headaches a few months ago. I obviously complied and went to the room. I entered, greeted the man, a large Hispanic man in boots, jeans, a button up flannel shirt, and wearing a large cowboy hat. I noticed on his vitals that his blood pressure was 180/95 that morning and I interrogated him humorously about why his blood pressure was so high. He smiled and said that he ran out of blood pressure medications because he has no transportation, no money, and lived alone as most of his family was in Mexico. I conceded that those were good reasons to have to not be able to take medications but in the back of my head I thought he was exaggerating; he was well dressed, well groomed, seemed smart, and eloquent, he was clearly just making excuses that I, a naïve medical student, would believe. I spoke to my attending about what the patient told me and she went in, followed by a social worker, to speak to the patient. The man smiled, nodded his head, and agreed to abide to whatever my attending and the social worker suggested. The man seemed at ease, he expressed no concerns, and he left. I glanced at the clock, 1:35, total time of encounter: 32 minutes, in other words, way too long.

continued
The clock now neared 6 PM. My attending and I emerge from the last clinic room like fatigued marathon runners crossing the finish line. She smiles at me and says I can finally go home. I don’t argue with her suggestion, I never do. I grab my stuff and leave. As I head to my car a familiar hat catches my eye; a cowboy hat rendered useless by the night sky sits on top of a head whose face glances up and smiles at me. It was my patient, my one o’clock, patient #7, the follow up, the hypertensive patient with headaches. But no, he wasn’t either of those, he was a man, he was a person. At that moment, profoundly ashamed of my previous perception of him, I realized that he wasn’t lying to me, he wasn’t even exaggerating. He had no money, he had no transportation, he lived alone, he actually really truly did.

Healthcare disparities perhaps aren’t attacked with much force because we organize and stratify information in order to fit data sets, charts, and graphs. We fail to see humans as people, fail to understand individual human experiences, and thus we rid ourselves of the opportunity to nurture our sympathy for others who do not exist in the same socioeconomic realm. There are very few people in positions of power who have been exposed to the harsh realities of healthcare disparities. In communities such as the one I worked in, the lack of attention paid to the patient population is true medical negligence. We can remedy this with legislation but because allocation of funds and resources would be shifted away from people of power and people of wealth, the key isn’t to simply promote lawmaking but first to uncover the altruistic nature that exists in most people.

This experience helped me do just that by resetting my focus. I, who always claim I want to help the Hispanic population, was momentarily preoccupied with medicine as a job with a need to complete and not with medicine as a passion with a need to help.
When the nurse asked how I felt, 
I lied, said I was fine. A little pain 
when I thought of Sheila, an ache 
when I remembered all those mornings 
waking up beside Helen but overall 
I felt pretty good. *Try not to think 
about past loves*, she said, handing 
me a blue pill, a red pill, a pink pill. 
She said I’d feel better if I rested 
thought of nothing besides my work, 
sports, walking the dog, yard work. 
Anything but the women I’d loved.

After she left, my roommate, Paul, 
slid the curtain back, said *we should make a run for it.* 
I said, *but where would we go? We can’t outrun our past.* 
*I don’t know, man*, he said, *but anywhere must be better than here.* 
*What if we get caught?* 
*Oh, we’ll be caught*, he said. *The only way to get over love is more love.*

I closed my eyes, thought of my life 
before I knew love, late nights happy 
and alone, watching MTV, eating ice cream 
by the carton, bags and bags of Doritos.

I heard a laugh and looked up 
Paul was climbing out the window. 
He ran down the hospital’s front lawn, 
his long grey hair trailing him. Two nurses 
rann in and stood at my window, shaking 
their heads; one said *he’ll be back,* 
the other nodded, said *they always come back.*
When the nurse asked how I felt, I lied, said I was fine. A little pain when I thought of Sheila, an ache when I remembered all those mornings waking up beside Helen but overall I felt pretty good.

Try not to think about past loves, she said, handing me a blue pill, a red pill, a pink pill. She said I'd feel better if I rested thought of nothing besides my work, sports, walking the dog, yard work. Anything but the women I’d loved.

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I remember quite clearly the first time I met you. My heart was heavy. My throat was closed. My mouth was dry. I was about to start, and there was your hand right in front of me, a reminder that you were a person, a husband, a father, a son. There were people who loved and cherished you and I felt as if I was betraying them in some way.

I continued and I would force myself to focus on the area that I needed to work on, but my eyes would drift to your hand. The lines in your skin were a map, detailing the care you put into your life and the people that you held. So I stopped trying so hard. I patted your hand instead.

“Thank you,” I would say.

Weeks passed and I continued to study the maps that lined your body, your vessels and organs, and I would feel wonder. The arteries that wrapped around your heart showed me the affection you brought to the world. Your lungs still contained the air of the places that held you. Your muscles explained the way you carried yourself day to day. After I poured over these details, I would pat your hand a few more times.

Thank you.

continued
Dear Donor | Tesneem Tamimi continued

A patient is not a clean diagram of structures like the ones drawn in our textbooks. They’re messy and intricate and wonderful. Organ systems are not individual but are endlessly linked together. I remember I would study the diagrams of the organs we were dissecting that day and when I would stand beside you, it was as if all that information was a world of its own. I couldn’t help but think back to when I was a premed college student learning chemistry through models that were designed to help our understanding and didn’t measure up to what was happening in the real world. These pictures and drawings and cartoons of the human body were just that: a model. It’s safe to say that my understanding of the human body would’ve been incomplete without the gift I was granted. It’s only because of you that I know what a proper pancreas looks like.

So thank you. I’ve pursued medicine because I enjoy learning about people’s stories. And it’s your specific story that brings me awe. There’s nothing more selfless than what you’ve done for us. I may not have met you during your life, but I will forever remember you in your passing. You’re with me when I examine patients: when I press down on an abdomen, I don’t think back to the diagrams in my notes. I picture your organs in front of me.

I said my silent goodbyes the last time I saw you in the lab. I looked at your hand that I had practically memorized and a simple pat seemed so insufficient for our year together. So instead, here I am, telling everyone here that I’ll always carry you with me as a doctor in the future.

Thank you,
A medical student.
For months my feet swelled and were besieged by their own guards. Antibodies attacking joints and bones, so that now they are tender and their structure has changed. Some joints did not survive. The third and fourth metatarsals on both the left and right. All thinned with moth-eaten bone.

But I can still wiggle my toes, some better than others, and I can walk, so I see that my feet are more like soldiers who have survived an invasion and are preparing themselves for what lies ahead. And I suppose that could be celebrated.

I’m coming unmoored as I try to figure out who I might be if it’s true and I am sick, sick for the rest of my life. And no amount of googling will give me the answers of who I am or who I might become. It’s like trying to catch water in your hands and still, I keep grasping and still, I get back nothing I can hold onto.
He isn’t six foot six. Doesn’t weigh 300 hundred pounds or wear mirrored sunglasses. He’s not there to ward off stalkers or swarms of paparazzi.

My BodyGuard is the size of an ice cream sandwich and weighs just enough to drag down the elastic of my yoga pants when I clip him onto my waist. He’s there to track what my cardiologist calls tachycardia—the feeling that my heart is a live animal determined to race itself right out of my chest.

* * *

I’ve always been too aware of my heart. It goes into overdrive when I wake from nightmares and does double-time whenever I see an alligator gliding along the surface of the retention pond behind my house. I’ve felt my heart thump like a dog’s tail during body combat class and tick like a clock when I’m in Terminal B and need to get to Terminal E in five minutes or else I’ll miss my flight.

But right after I turn 57, I develop a blood disorder called pernicious anemia that leaves me constantly hyper-aware of my heartbeat—how fast it is, how uneven, how it belabors my already belabored breath. I get dizzy when I stand and nauseous when I drive and can’t go anywhere in public without fear of passing out.

A visit to the emergency room (where the attending physician asks me, “Have you been watching a scary movie?”) later leads me to the office of The Bad Cardiologist, who—without laying either a hand or a stethoscope on me—dismisses my jumpy heart as menopausal.

I suffer another four weeks of walloping heart and another visit to the ER (where Attending Number Two asks me, “Have you gotten into a fight with your husband?”)—before I land an appointment with The Good Cardiologist.

The Good Cardiologist asks respectful questions and listens to both my answers and my heart. He spends a lot of time gently pressing his stethoscope against my chest and back. He feels the pulse in both my wrists and ankles. He says he can’t find anything amiss. But because I might have something hidden—maybe a slight tear in the mitochondrial valve—he orders an ECHO and a stress test and a monitor that will track my heart rate and rhythm for the next thirty days. These three things combined will determine if I need surgery or electrical intervention in the way of a pacemaker, or maybe just a daily dose of betablockers to keep my heart from going beep-beep! beep-beep! like the cartoon character, Roadrunner.

* * *

When BodyGuard arrives in the mail, I call a toll-free number in Houston and a sweet girl with a Texas twang walks me through the set-up instructions. BodyGuard comes in two parts. There’s the frog-sized box I attach with electrodes to my chest and then there’s the phone I clip onto my belt. I think of the phone as the Guard because he’s the one who—through his green and gold monitor lights and preprogrammed text messages—communicates with me.

Initially I find BodyGuard a friendly soul. He has the best of intentions: to keep me safe. When I unclip him from my belt and leave him sitting by his lonesome on the bathroom counter or abandon him on the coffee table to go outside, he buzzes to remind me I’m too far away for him to protect me.

I’m flattered. No one has ever been so concerned about my whereabouts before. So I start flirting with him. One day I program him to talk to me in the language of love: Italian. The next day, French. I mess around with Tagalog. Consider a fling with Mandarin.

continued
BodyGuard | Rita Ciresi continued

I revert to English because it's important to understand exactly what he has to say. BodyGuard reminds me when we have poor skin contact and wakes me up in the middle of the night to let me know I'm not within transmitting range. In return, I'm supposed to talk to him by pushing a button to record an "event," such as shortness of breath, lightheadedness, rapid heartbeat, irregular heartbeat, fainting.

But I'm a woman. And he's a guy. Or at least I think of him that way. So I don't want to push the button and bother him, any more than I once wanted to rouse my dad's ire by waking him as he snored on the couch.

For the first week I only push BodyGuard's button twice. Then I get honest and begin recording every event: how breathless I get climbing stairs. How lightheaded I feel just walking to the curb to fetch my mail. How my heart wallops when I'm folding laundry. How I feel like I'm going into cardiac arrest just bending over to take a plate out of the dishwasher.

The more I confide in BodyGuard, the deeper my affection for him grows. Now here's a man who listens (even if he does say very little back). I try to convince myself there's nothing weird about our relationship. Plenty of famous women have fallen in love with their bodyguards. Princess Di called Trevor Rees-Jones her "rock." Princess Stephanie of Monaco married her bodyguard (but divorced him a year later).

BodyGuard and I, however, are definitely a short-term fling, since 30 days is the maximum my HMO will pay for us to stay together.

Good thing, as our honeymoon together is short.

Some psychiatric patients are convinced Donald Trump is talking to them through the microwave or that Satan is calling out to them through the refrigerator's hum. Some are so paranoid they won't permit a physician to put a stethoscope on their chest, for fear the doctor will hear the inner voice of their heart.

Maybe these patients are onto something—or maybe I need to check into the psych ward myself—because the longer I wear BodyGuard, the more I start to wonder: is there someone on the other side, back in Texas, who is doing more than recording my heart rate? Can Houston hear all the sick thoughts coursing through my brain? Does Houston see my nightmares of alligators and whales and tsunamis? Does Houston know when I am hungry or sad or depressed?

I fear I'm being monitored, à la 1984, and the more my paranoia increases, the more I fear The Bad Cardiologist was right. I don't need a pacemaker. I need a higher dose of estrogen and a dollop of anti-anxiety medicine.

Two days before his allotted time is up, I break up with BodyGuard and ship him back to the land of cowboy boots and Stetson hats. Houston reads my data and sends it to The Good Cardiologist, who—in the absence of any physical evidence of abnormalities—puts me on betablockers to smooth out the rhythm of my heart.

I love the betablockers. They make me feel like someone has taken an iron and steamed out all the wrinkles from my body. But for weeks afterward, my hand keeps going to my chest where the frog-like electrode box once sat. My heart still longs for something.

What?

Here might be an answer: Once my sister took me to Bikram Yoga. The room was heated to 105 degrees and set at 40 percent humidity. I never sweat so many toxins out of my body in my life. At the end of class, as we all lay down in corpse pose, the teacher walked from mat to mat, assessed our energy, and placed a warm stone on the part of our bodies where he thought we most needed comfort.

He put the smooth rock right above my left breast—a simple, caring act that made me realize that sometimes we all could use a bodyguard to monitor the ups and downs of our hearts.
After talking us through the grey-scale rendering of a tumor universally signaling
End of the line,
Truly misnamed after a biphasic bug,
He solicits any questions.
I reflexively say no, but then,
Turning back to her intubated frame,
Request to know his goals today.
“Groundbreaking”
Trials stretch survival from 13.1 to 13.8 months,
And despite already devouring her right-sided vision,
That heterogeneous mass remains insatiable.
No amount of creativity could fabricate an attainable definition of
“Win.”
His shoulders deflate faster than her bag ventilation mask,
And instead of answering, he wonders aloud if his field needs more
Scientists or poets.
Looking back at the necrotic metamorphosis of her sense of self,
Probably both.
Probably both.
Broken Heart Syndrome | Christian Bergman
It is not a child’s game or a fairy tale, 
not her job, 
but her affliction, 
not just to keep them safe 
but alive. 
When was the first time? 
Her grandmother, 
who had held her on It’s a Small World. 
Over and over they rode the waves. 
Her heart’s delight at three. 
She remembers the day 
of her grandmother’s fragility 
and her responsibility. 

Was she complaining, a little girl—seven—
distracting her grandmother? 
Then a twisted ankle in a boat dock 
A paper bag to regain breath, 
in and out. 
The natural denaturalized. 
Dead a year later. 

Had the invasion already begun? 
Or could the magical thinking of a child, 
to be good and 
to sign her grandma’s initials, 
have saved her, 
if the little one had just performed the trick 
one more time 
or a thousand? 

She was willing. 

Just as she was willing 
when her father slipped 
and broke his finger, 
or the car slid off the road and he broke 
his collar. 
For a count 
—one, two, three— 
there was no heartbeat, 
only those metal paddles. 
She slinged his arm. 
She delivered calm. 
She knew she soothed them all. 

Just a child. 
Not a game.

Then her brother on the floor 
too tan, a shade of tangerine. 
Still unlicensed to drive, 
but she had her finger on the pulse 
of who to call 
and who to guide 
to the hospital for another 
operation, another 
close call. 

Most in her care were hearty, 
it was true, 
but all could fall to 
sickness and sadness. 
Even her husband. 
No longer a child her condition remained, 
a fluttering nightingale of 
ease amid disease. 

She knows this ache is 
no more than others take, 
much less than some: 
these maladies, 
this pain, 
this world of fear 
of what’s to come. 

A faint and a fall, 
Body to ground sound 
a harsh cacophony. 
Discord from other rooms 
like shots over the next ridge. 
Who is down? 
Who needs care? 

One day she knows she will fail them, 
Not put them back together like Humpty Dumpty. 
She tries to stave off that day 
planning for potential problems, 
searching for the clues, 
picking up the pieces as she goes.
Melt | Jenna Kay
“There are kitty-cats on the ceiling!!”

A welcoming, if not unnerving, exclamation from my first patient on my first week as a clinician-to-be. Found down at home, disoriented and often incoherent, my first patient was perfect, but imperfectly so. He shouted, threw off hospital blankets and refused pain medications with more force than would be expected from a 97-year-old man plopped down out of the blue in our ED hospital bed.

“Is that you, Kathy?”

His soft voice, lack of hearing and MIA hearing aids forced me to lean close, bending myself over the bedrails and ramping up my big-girl voice to reach into his elderly ears. Shaking hands and flailing arms constantly trying to pry himself from the hospital bed and out into the halls towards freedom required constant handholding and more than a few creative arguments to keep him in place. Fragile, thin and friable skin, at risk to bleed from chronic blood thinners, necessitated a constant and careful, gentle touch. A waning memory that let him confuse me frequently for his oldest daughter – Kathy – prompted frequent re-orientation and re-framing, trying to bring him back to the reality of those beige colored walls and linoleum floors, away from the nostalgia of the wood panels of his family home.

“I am a chocolate pudding kind of man.”

For a new third year medical student, this patient, requiring so much hands-on-voice-on-attention-on care was a gift. The little spaces around his primary medical care were perfectly suited for an enthusiastic, energetic medical student to fill with attention and company. Facing my ineptitude in most things clinical or technical, I found that I was instead very qualified for a few basic, essential skills not found in medical school curriculum. Listening to his stories about his daughters and the wife showed me a father proud of his life, devoted to those he loved. Sitting by his bed spoon feeding him pudding gave me a chance to learn that he was a chocolate, not vanilla type of fellow. Holding his callused hands gave the impression of a man who spent most of his time outside doing work, that this new state of deteriorating confinement was a state foreign to him, and one he never would accept as normal.

“Suffering. I am suffering.”

Hours ticked by while we rounded, wrote notes, performed physical exams on patients across the hospital. For each new discharge and hopeful recovery we encountered, our patient on the 4-South wing dropped a little further into delirium, his hemoglobin and platelets a little further towards severe. After two days on the medical floor, he deteriorated, needing more care than our team could offer. The next time I saw him, he was propped up in an ICU bed, a new host of lines, tubes and drains surrounding his bed where family should be. In and out of consciousness, the once bright and clear cerulean eyes now looked hazier and grayer. He stirred awake during a morning blood draw and we met eyes. The few words he whispered out were those of suffering, our last conversation ending in an ominous fit of blood streaked coughing.

“He was the most active 97-year-old I knew.”

The next day his daughters arrived from out of state, in states of emotional shock not unlike the place of physiologic shock their father now lay in. They told me in nostalgic tones of their father’s life of energy and enthusiasm. I watched the gasping figure in the bed before me as they talked of his colorful life before the beige walls of the hospital took him hostage. I tried to picture him playing basketball in college, the curled up figure in front of me had once stood broad shoulders at 6’3”. He had a hunting trip in Canada scheduled in a few months, his hands now bruised and bloodied from repeated needle sticks and blown IV lines. His daughters tried to dissuade him from his daily walks with his dog around the retirement village in the 100+ degree heat, he hadn’t been able to sit up since he arrived on a stretcher several days before. The man they talked of was not this suffering figure in front of us. I leaned down to say goodbye to my first dying patient. He squeezed my hand, and nodded in a way that my over-invested heart took to mean he knew. He was still there, somewhere deep inside, perfectly human though his body now was imperfectly failing.
I thought I knew what next year would hold, another child, another year working at the same job, a chance to fix the siding on the house, my husband next to me, my son learning to talk, but I don’t know.

We can't know if there will be another lazy summer with time enough to put new siding on or if another child will come or if the things and people we hold dear will still be there to hold.

We believe they will, we have to believe that. We believe we have nothing but time spread out in an endless expanse, but we don’t know.

When I found out that I am sick sick for the rest of my life I watched that whole expanse shrink down to a single moment. I don’t know next year or tomorrow. I only know what I can do today I can only finish the work in front of me hold the child I have now kiss my husband now and I can’t know what tomorrow will bring.
They Prepare, They Journey, Some Arrive. | Paulina Joanna Ramos

“Breathe.
You are here.
Take a deep breath in, and out…"
Their sighs are wordless prayers.
That morning we learned about 44 different experiences.
44 different journeys and destinations.
All 44, however different their journey may have been, exhibited sighs of relief, of peace, of comfort.

Comfort. Many of these individuals had to break the barriers of their comfort zone.
They hope to find a better opportunity for their lives; such as the American Dream.
Many left their home, their safe place, their loved ones.
Some were fortunate enough to arrive in two weeks.
Others have endured months of suffering.

Suffering. “Hemos sufrido” (we have suffered).
One father tells me, as he holds on to his son’s hand with tears in his eyes.
They left Honduras two months ago.
They saved money to pay the “coyote” (guide) who lead them, and others, across the border.
They recount the process and the journey.

continued
They prepare to leave.  
They pack lightly.  
They do not know what lies ahead for them.  
They prepare and pay for a journey into the unknown.  
There are days with no food, no water.  
While some may travel by bus, others walk.  
They walk in the desert sun without food...cross bodies of water and walk with wet shoes...  
They drink water from hoses and wells along the way.  
Then they climb a mountain covered in cacti to cross the border.  
They travel and suffer through unimaginable distances.  

Distance. They distance themselves from their home, from their family.  
They arrive in a foreign country, some with a spouse or children.  
They travel for days, weeks, and some for over a month.  
Then, they find themselves in Tucson.  
Their children...  
Their children know they are in a different place.  
They remember the journey.  
They do not complain.  
They eat their soup and fruit upon arrival, pick a stuffed animal buddy, and sit with their parents.  
They ask for seconds and smile when we hand them a second serving.  
They are hungry.  

They sit with their parents during the registration process and color or play with their new stuffed animal.  
They are introduced to the Monastery, the toys people have donated, and the art room.  
Some play outside while others come to the art room.  
Some draw their favorite cartoon characters.  
Some draw the pets they left at home.  
Others spell out the name of their home country.  
And some...some draw the homes they left behind...  
“It’s just me and my dad...my mom stayed with my little brothers in Guatemala,” a boy tells me. “They were supposed to come after me and my dad, but the road here was too rough and my dad does not want them to come alone.”  
And so, some children draw the family members they left behind...  
A home they loved, despite the danger and poverty.  
Because it was a place where they created memories, a place they knew.  
A place they called home.  
Their drawings are filled with restrained emotions and unspoken thoughts.  
This distance they traveled with their parents, has taken them far from home.  
Far from what they know.  
And in search of what?  
In search of hope.
Hope. Hope that they will provide their 10-year-old child with a leukodystrophy and G-J tube with adequate healthcare.

Hope that they can escape the dangers of their country, so she can give birth to her baby boy without worrying about ongoing shootings in their local hospitals.

Hope of providing the means to pay for his son to receive a good education, and a better opportunity for his life.

Hope that she will be reunited with her husband who came here before to earn what for them is, a better living. See, these immigrants come, knowing that they may be deported.

That all of their efforts may be fruitless.

They come, knowing that they will work hard labor, low paying jobs.

While some will stay with sponsors, others will try to work and live on their own.

They come knowing that they will struggle at first, that it will not be easy.

They have heard of others who have died on their journey, who have been kidnapped, tortured.

Still, they risk it all...

They have hope that things will work out.

Hope to thrive and live, not to just survive.

Survival. It is an innate intelligence, a skill.

The intrinsic wiring and hardware inside of us...

The molecules, the chemical and electrical impulses signaling each cell to sustain the organ.

The organ, functioning as an essential component to our body.

Each and every interaction occurring in our bodies is intended for our survival.

Many of these individuals have been exposed to conditions that alter the homeostasis of their body.

Many arrive dehydrated, with abdominal cramps and diarrhea.

Many have headaches, fever, or bodily pains.

Some are suffering from pharyngitis, sinusitis, or otitis.

Many acquire lice, ringworm, athlete’s foot, contact dermatitis.

Some ran out of medications for their hypertension, hyperglycemia, or their chronic neuropathic pain.

Many of the women travel in their third trimester of pregnancy or with their newborns.

Some arrive with injuries from the journey.

And some...thankfully arrive in a good state of health.

Those in need, receive medical care.

Care. We’re here because we care.

We take time from our days, from our jobs, our schedules, from our lives.

We volunteer.

Each day that we are there...each person who arrives, each smile we receive, each smile we give;

We find joy in losing ourselves in the service of others.

The essence of medicine lies in the patient-physician interaction.

It lies in the trust the patient has in the physician...

And in the compassion and dedication we have for our patients.

We care about these individuals.

A life is a life to us.

It does not matter where that individual comes from, or what they look like, or what they have done;

We will provide them medical care to better or save a life.

continued
They prepare, they journey, some arrive. I Paulina Joanna Ramos continued

Life. We only have one life.
We only have one body.
They know that this sacrifice can provide their family with a better life.
The suffering partially ends when they sit on the church pews;
They have arrived.
They sigh with relief as they hear that we will help unite them with their sponsor.
They thank us when we give them fruit, water and soup.
Yet, what touches me the most is how they hold their children, how they place their hands on their chest.
How they kneel and close their eyes or tear up, as they begin to pray.

Pray. They pray to their higher power.
They thank us for helping them.
They remember the days before they left, when they were preparing to leave their home and their families.
They recount the adversity they faced on their journey.
They pray and feel blessed to be here.
Not all are as fortunate.
Others did not make it to the Monastery.

They prepared, they journeyed, some arrived.
He’s climbing a ladder
hands reaching, grasping
at the air, mouth wide
white beard quivering
clear, blue eyes fixated
on some distant point
beyond

They do that before they go
you know, she says,
peering through the blinds
You know—the kind you adjust
from outside the room
and as we look in
he looks out, but past us
eyes searching
beyond

They do the climb, she says
to heaven, the skies
Who knows?
He looks at us, mouth gaping
eyes wide, caught between
the material and the great
beyond
That clear-skied morning in April 2006, I had no idea that anything was amiss. I awoke, walked the dogs, ate breakfast – the usual: scrambled egg whites and toast – and dressed for work. I looked forward to the weekend, as it was Friday. Nothing about the progression of hours drew my attention as anything other than a mundane end of week. By lunch, I was beginning to not feel well and so I forewent eating. By quitting time, I was in agony.

I managed to drive myself to the local emergency room, a recent addition to our tiny town, rising like a cathedral above the Colorado plains. Stumbling in through the pneumatic doors, I found my way to the registration desk where they handed me a clipboard and a stack of forms to fill out. I did my best, though it was difficult to focus on details while hunched over the clipboard like Quasimodo. Handing the clipboard back to the nurse on duty, I returned to an empty seat and tried to get comfortable while it felt like a hot fire poker was being jabbed repeatedly into my belly. Realizing that I couldn’t sit upright for any length of time, I crawled beneath the row of chairs and curled up into the fetal position.

Pain forces us to focus on each excruciating second, stretching time indefinitely. It was an interminable wait. Finally, my name was called. By that time, I couldn’t straighten up to walk, and hurried across the waiting room hunched over, arms wrapped protectively around my abdomen.

There are many ways in which opportunistic illnesses can take control of our immune systems and wreak havoc. We don’t like to think about it, to think about how many viruses and bacteria there are inside us right now fighting for supremacy.

A Center for Disease Control report recently stated that over half a million bacterial cells can be found in the average sink drain, and that’s just the sink. The bathroom is a veritable font of found bacteria; over 5 million cells in the average bathroom sink, toilet, and tub. So I suspect we are exposed to hundreds of millions bacterial cells every day, most of them intent on causing us harm.

The bacteria that dwells in our bodies is constantly racing around like a gang of juvenile delinquents looking for something to vandalize or destroy. At the same time, white blood cells act like microscopic police officers trying to prevent the delinquents from getting away with anything.

In the emergency room, I was examined by a weary-looking woman in crimson scrubs, hair amuss, dark circles surrounding her eyes. I wondered when the last time she’d slept was. However, I wouldn’t have cared if Doogie Howser himself had shown up. I wanted two things: strong drugs, and for the pain to go away so I could set about forgetting it had ever been there.

After my vitals were recorded, I was handed a thin cotton gown that tied in the back. It’s funny how modesty flies out the window when you can’t breathe because you hurt so bad. I was led to an unoccupied area of the ER that looked like it doubled as a surgical theater, and felt as if it was 90 degrees. Heat exacerbates pain. The nurse said the heat was stuck on, though someone would be there in the morning to fix it.

“In the meantime, I’ll set a fan in the doorway for you. You’re going to be here until tomorrow.”

“Why?” I asked.

“Well, there is no surgeon available right now who can remove your appendix. We’ve put a call out to the on-call doctor. We’ll let you know the minute we hear from him.”

She gave me a mild painkiller to take the edge off the pain and got me settled into bed, returning moments later with the promised fan. Afloat on a chemical cloud, the pain subsided into a dull ache, and with cooler air being forced into the room, I dozed. Appendicitis, if not treated quickly or properly, can be fatal. Should the appendix burst spontaneously, it spews infectious materials into the abdominal cavity. Once that happens, peritonitis can set in and an immediate regimen of strong antibiotics is necessary to avoid death.

continued
Pain is the hammer of the gods. It's transformative, if we survive, and if we allow it to be.

Ten hours later, I hadn't heard anything from hospital staff. By that time, a new shift had come on duty. Using the call button, I summoned a different nurse. I asked what the hold up was.

“We’re unable to reach a surgeon that's covered by your insurance,” she informed me. Really? I wanted to scream. There’s not one person anywhere qualified to take care of this? But I held my tongue for fear of alienating her and being unable to request any more pain medication. I felt a bit like James Caan's character in the movie “Misery,” being held hostage in bed. All I needed was Kathy Bates to show up with a sledgehammer and a hobbling block.

Twelve hours, nothing.

Fifteen hours. They'd located a surgeon, but he was on the golf course and would be awhile.

Sixteen hours, I felt my appendix burst. If I thought the pain had been bad before, I was sadly mistaken. It was the difference between being pleasantly sedated and having the sun go supernova inside you. I became incoherent. All I could do is writhe around on the bed so frantically, I worked the sheets right off it. Tears streamed from my eyes. Finally, a kind nurse gave me an injection of morphine.

Bliss.

Seventeen hours and several more shots of morphine later, word came that the surgeon was nearby and would be there soon. Staff promised to keep the morphine coming. It was my only hope. By the time they wheeled me into surgery, 18 hours after I had arrived, I was delirious and barely noticed when they put me under.

The evolution of scientific research has helped us appreciate that the pain experience is more complex and highly multifaceted from the subjective to the specific. The individual nature of pain is highly variable. I shattered my ankle when I was 12 after falling 50 feet from a tree. I thought then that I’d never experienced anything that horrible. When I reached my late teens, I began experiencing kidney stones. It's said that the pain of a kidney stone far outweighs that of childbirth. But how can we know that? I may see the color blue differently than someone else in the same way that I feel pain differently. My tolerance level, by my own admission, is fairly low. Throughout several decades I passed more than 30 kidney stones. The pain grew worse rather than easier to tolerate.

Pain is a wholly perceptual experience. There’s acute and there’s chronic, with the latter being defined as pain that lasts longer than one month beyond the normal healing period or that is associated with a pathological process that causes continuous or recurrent pain over months or years.

I met with the surgeon a week after my appendix had been removed, when he explained that my abdominal cavity had been a ‘hot mess.’ His exact words, and unfortunately all too accurate. What he didn’t tell me, though, was that because of the toxic sludge that had fountained into my body, my immune system had been completely wiped out.

It was something I learned four months later.

One of the reasons I love Colorado is its natural beauty. I lived with my three dogs on the edge of 12 square miles of protected open space. We walked that land every day, encountering all types of fauna: owls, prairie dogs, skunk, deer, rabbits, bald eagles and the ever-present predator…the red-tailed hawk. It was the circle of life right outside our door. Afternoon squalls provided standing water in low-lying areas that attracted marine life like tadpoles, dragonflies, frogs, turtles, snakes, and my least favorite: mosquitos.

After a particularly wet spring, mosquitos were found swarming all over the county. Doctors warned of insect-borne disease. Town officials hired independent contractors to spray the worst areas. In spite of my aversion to them, I still had to walk the dogs as there was no fenced area to pen them in.
One morning in August, just after sunrise, we were walking through a nearby park. It grew warm early, so we didn’t stick around too long, as there were several ravines that still had water in them. Mostly I was concerned for the dogs. Mosquitos lay their eggs in ducts in the inner part of the eye, which hatch and become heartworms, which could kill them. We hurried through the remainder of our walk and headed home.

My roommate then was a disabled man who couldn’t work, but could take care of the dogs when I was at work, creating a mutually beneficial relationship. He was also a heavy smoker, which wasn’t a problem as long as he took it outside onto the patio or somewhere away from the house.

One early morning I awoke to find 20 or so angry red welts on my legs. I looked at the ceiling to find it lousy with mosquitos. I found the roommate in his room. “Did your leave the patio door open last night when you went out to smoke?”

He shrugged. “I might have.” I showed him my legs. He apologized. Nothing that I could do about it but caution him to keep at least the screen door closed when he went out. In the bathroom, after a shower, I slathered pink calamine lotion on my legs and headed off to work.

Several days later, I noticed a strange rash on my chest and shoulders. It didn’t itch and the skin wasn’t tender, so I thought it might be heat rash or something and ignored it. It was gone within a day.

Three days later, I came down with what I thought was the flu. Every millimeter of skin hurt. My joints felt like they were being pulled in different directions at the same time. My eyeballs hurt. I ran a fever of 103. 105.

I was nauseous. Nothing worse than a summer illness, I thought, lying in bed with a pillow over my eyes because the light hurt. Three days, and I wasn’t getting any better, so I called out to my roommate to ask if he could take me to urgent care. He agreed.

He helped me to his car, as I was really weak; weak enough that I feared falling down because my legs wouldn’t support me. My head pounded like Thor himself was inside it playing the Anvil Chorus.

continued
On the short drive over, I found that my right arm and leg were trembling uncontrollably. The roommate practically had to carry me into the building.

The staff took one look at me and hurried over with a wheelchair. Though I was in tremendous pain, I tried to describe my symptoms, but couldn’t think very clearly. They were concerned enough to get me into a bed right away.

Later I would learn that I had become unresponsive, that I had lost consciousness. I regained a foggy sort of awareness sometime later to realize I was in an ambulance, and then blessed darkness for a long while.

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The staff at nearby Boulder Community Hospital were very concerned when they couldn’t revive me, and placed me in a negative pressure room, as they also had no idea what I had become infected with, and I wasn’t in any condition to tell them.

A negative pressure room is a safety measure used by hospitals to prevent cross-contamination into the rest of the hospital. And since they didn’t know what they were dealing with, they took few chances. If I had any kind of communicable disease, it would spread quickly unless they took proper precautions. It’s often used for airborne contangions like tuberculosis, measles, or chicken pox.

In order for the staff to enter the room, they had to don Tyvek hazmat suits. The few times I surfaced, I thought I was in the Universal Space Station, before I slipped under again. The pain I experienced was far different from appendicitis or kidney stones. Those events had very specific pain centers, usually where the inflammation occurred, or where the object was in my body. With this, the pain was all consuming. It wracked my body, and the ongoing tremens on the right side of my body only made it worse. Hospital staff were unwilling to give my any sort of medication or pain killer, at least until they understood what I had. I was eventually moved from the negative pressure room to a private space in the emergency room where they could continue to keep a close eye on me. I vomited numerous times, but because I had been unable to eat anything for several days, not much came up. They began a series of lumbar punctures to have a look at my spinal fluid, thinking maybe they’d find an answer. I had come around again, but the pain of my body was so intense, I barely felt the needle piercing my spine. After seven or eight of those, they finally isolated the illness: meningitis and acute encephalitis. From there, they began to put together a narrative about what might have happened. It was only then that I was able to relate about the mosquito bites, and found out that I had contracted West Nile Virus, which wiped out what little immunity I had been able to build up since the previous April, leaving me susceptible to nastier illnesses. They checked repeatedly on my pain levels, which I told them rated an 11 on the Wong-Baker pain scale, which only went to 10. I think there’s a joke in there somewhere from the movie This Is Spinal Tap, but I don’t remember what it is.

Later, I learned that I had also stopped breathing twice during those scary few hours after I was first admitted, and had to be revived. I remember none of it.

After 10 days, I was released to go home. I was still weak and disoriented. The illness had completely wiped out my short-term memory. The right side of my body was useless, and I feared I might never regain full functionality again. I was thankful to be home, however. Over the next three years, I worked diligently at regaining my life. I played memory games with myself until I was able to retain the information. Being right side dominant, I had to relearn how to eat, brush my teeth, and dress myself. My employer had placed me on long-term disability, but I wanted to return as soon as possible. Sitting around the house was not helping me. I needed something other than my health to focus on for a change. Through the support of my friends, dogs, and my refusal to give up, I made a full recovery. Some others who had acquired similar illnesses weren’t as lucky.
There are innumerable types of pain. Medical science classifies pain by the kind of damage that causes it, like tissue or nerve damage. But it doesn’t recognize the pain of a broken heart when a beloved dog dies or we lose somebody in an accident. It doesn’t count the mental anguish we feel when someone we’re close to decides the relationship is over. It can’t cover the pain of witnessing abuse of a friend or an animal. So in addition to physical pain, there is the pain of suffering through which we might be able to view various aspects of human life.

“Did you ever say yes to a pleasure?
Oh my friends, then you also said yes to all pain.
All things are linked, entwined, in love with one another.”

--Nietzsche

Pain is always subjective. Each of us learns the application of the word through experiences related in early life. Often pain is physical, but more often it is psychological or even spiritual. There is a school of thought and theory called philosophy of pain, putting forth the idea that living involves being exposed to pain every moment, not necessarily as a persistent reality, but as a possibility. When we pursue happiness, we pursue a life without the presence of pain. Yet, would we be able to know pleasure if we never knew pain? It reminds me of a philosophy class I took in college, in which it was posited that we would be unable to see light if there was no darkness. There is not one without the other.

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Pain changes you. Not only in biological ways, but in fundamentally life changing ways as well. It makes you stronger, or it kills your will. Like a gale force wind, it drives you either forward or backward. It changes the way you view the world, but more specifically, it changes how you view life. In the thirteen years since that illness, I have stopped taking things for granted. I’m constantly surprised at how I find beauty even in things that other people might call trash. My focus on creativity has increased exponentially, and I no longer skip writing days because I know that today, tomorrow, or even an hour from now, some catastrophic event might take place and I will lament the things I wished I had done. I realized that it costs nothing to be nice to people.

At the same time, I have little patience for people who suck the joy out of others, out of life. I don’t judge them. I understand that they have not yet reached a place in their life where they realize that it could all disappear in the blink of an eye.
I’ve Stepped Into the Day | Kaela Hiatt

After far too long, I’ve stepped into the day
Felt her golden light washing over me
The Sun’s warm embrace caressing my shoulders
The way mothers pull children close after nightmares
I close my eyes as she lays kisses on my face
On my freckles, my nose, my forehead
A tear trickles softly down my cheek
For years I’ve longed for this moment
Trapped in an endless winter night
The nostalgic memory of daylight stored in my mind’s basement
Collecting dust and withering away -- nearly forgotten
Until the ground quaked and unearthed her from her tomb
She is familiar, like an old childhood song
As inviting and forgiving as I remembered her to be
I reminisce in the melody and it takes me home
After far too long, I’ve stepped into the day
And I won’t ever take her for granted again
AUTHORS & ARTISTS of HARMONY

Abby Manzella – is a writer and scholar with poetry and prose at sites like Feminist Studies, Frontiers, The Rumpus, and Lit Hub, and a book, Migrating Fictions, which was named by Choice Reviews as an Outstanding Academic Title.

Bethany Boczar – is a fourth-year medical student at the University of Arizona College of Medicine - Tucson, who enjoys photographing nature when she has a free moment outside of medicine.

Caitlyn Myrdal – is a third-year medical student at the University of Arizona College of Medicine.

Cara Popeski – is a second-year medical student at the University of Arizona College of Medicine who loves desert skies and hearty laughter.

Carol Lynch – is an artist at ArtWorks, an outreach program housed in Sonoran University Center for Excellence in Developmental Disabilities at the University of Arizona, Department of Family and Community Medicine.

China Rae Newman – is a third-year medical student at the University of Arizona College of Medicine, and is inspired and motivated by the connections that medicine allows us to make with our communities, and believes that life is best lived with enthusiasm, effort, and kindness.

Christian Bergman – is a third-year medical student at the University of Arizona College of Medicine in Tucson.

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Elizabeth Shippen – is a mother, writer and Agile Product Manager living in Massachusetts.

Heather R. Sim Liber, M. Admin - is a UA and NAU alumni working as a Program Manager in the UA Center for Innovation in Brain Science, and is a distance runner, Disney fanatic, avid photographer, and mixed-media artist.

Helen Collins Sitler, Ph.D. – is a western Pennsylvania native, and a Professor Emerita from Indiana University of Pennsylvania where she taught in the English Department for 20 years.

Jacquelyn Rose Hoffman – is a third-year medical student who has always had a knack for journaling and documenting life in tattered notebooks since a young age. She intends to pursue Emergency Medicine and to continue to write her way through her medical career.

Jenna Kay – is a second-year medical student at the University of Arizona who has been painting for 10 years; she owns her own Etsy store where she sells prints of her artwork.

Jennifer Nehls, MSSW – is a Social Worker working in the ICU at Meriter Hospital in Madison, Wisconsin.

Joan Nambuba – is a third-year medical student at the Cleveland Clinic Learner College of Medicine of Case Western Reserve University who has a keen appreciation for narrative medicine and how patients’ stories serve as the foundational basis for optimal care.

Joanna White – is a music professor who has numerous published creative works, a “Poetry and Medicine” column of The Journal of the American Medical Association (JAMA), and her poetry collection, Drumskin and Bones, will be published in 2021.

John D. – is a guy who’s just here, loving that hospital smell and feel, and is a University of Arizona medical student.
Jordan Bohannon and Mariel Piechowicz – Jordan is an artist who lives and works in Tucson, Arizona. Mariel Piechowicz is a fourth year medical student applying to psychiatry.

Joshua Sheak, MD, Ph.D. – is an intern at Cincinnati Children’s Hospital and this is his second essay publication (his first was published in North Dakota Quarterly in Winter 2016).

Julia Freeman – is a fourth-year medical student at the University of Arizona College of Medicine, who is an avid traveler with a love for capturing the beauty of nature in every place she visits.

Kaela Hiatt – is a first-year medical student, a healing healer, survivor, and aspiring Emergency Medicine physician with hopes of improving current ED policies on psychiatric patient care.

Kathie Zhang – is a fourth-year medical student at the University of Arizona College of Medicine - Tucson.

Kathryn Huber, M.S. – is a fourth-year medical student, lover of all things bioethics and humanities-related, and hopeful future geriatrician.

Kayenat Aryeh – is surreptitiously cat-dancing in the dark.

Kris Hanning – is a University of Arizona Health Sciences photographer in the UAHS communications department.

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Laura G. Goetz, M.S. – is an overly enthusiastic medical student (at Columbia University College of Physicians and Surgeons), writer, photographer, biker, runner, potluck host, and research dork, with the goal (as both an artist and a doctor-in-training) of helping people feel seen.

Lindsey Lepoidevin – is a fourth-year medical student at the University of Arizona who has adopted painting as a means of reflection throughout her medical education and is pleased to share her mixed media painting titled Stroke.

M.S. Mostamandy – is a fourth-year University of Arizona medical student in the Class of 2020.

Marcia Leiser Zaccaria – uses collage, with its layering and juxtapositioning of images, to explore the complexities of the human condition.

Marcus Lyons, M.F.A. – is an award-winning writer, artist, and educator, living well outside his comfort zone on the northern great plains of America.

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Michael Leach, Ph.D. – is an Australian poet, pharmacy graduate, biostatistician, and health researcher who has published poetry in a range of journals, including the Medical Journal of Australia, Medical Humanities, Meniscus Literary Journal and Cordite Poetry Review.

Michael A. Zaccaria – is a historian who studies human behavior over time and a photographer who captures human individuality in the spontaneity of the moment.
Mohamed Buwe Osman, MD – is an American Board Physician, visual artist, and writer.

Natalie deQuillfeldt – is a third-year medical student, one of the editors for Harmony Magazine, and a contributor to “Diverse Topics in Medical Humanities,” an elective offered at the University of Arizona College of Medicine in Tucson.

Niels Mohty – is a first-year medical student and an avid nature and wildlife photographer.

Nina E. Cerfolio, MD – is a Clinical Assistant Professor at Mount Sinai Hospital in New York City, teaches third and fourth year psychiatry residents, and is in private practice in Greenwich Village.

Paul McLaughlin – is an artist at ArtWorks, an outreach program housed in Sonoran University Center for Excellence in Developmental Disabilities at the University of Arizona, Department of Family and Community Medicine.

Paulina Joanna Ramos – is a second-year medical student who finds her harmony in helping others, nature, music, travel, and spending time with loved ones.

Phil Nerges – lives in New Jersey with his wife Donna, and has sat with more than 3,000 distressed patients over the last six years at a hospital near New York City.

Philip Dean Brown – works at the University of Arizona Health Science Library, and has had poetry and fiction published in a number of literary magazines.

Rick Kopstein – is a photographer in the BioCommunications department at the UAHS.

Rita Ciresi – is author of the novels Bring Back My Body to Me, Pink Slip, Blue Italian, and Remind Me Again Why I Married You, and four award-winning story collections, Female Education, Second Wife, Sometimes I Dream in Italian, and Mother Rocket.

Rosie Lizarraga – is a University of Arizona alumna, class of 2015 from the Molecular and Cellular Biology department, and currently works in the Department of Medicine as a lab manager.

Ryan McPherson, DO – is a 5th year general surgery resident in Phoenix, Arizona who will be pursuing a fellowship in trauma and critical care upon graduating.

Shrey Goel – is a medical student at the University of Arizona College of Medicine.

Steve Cushman – has worked as an X-Ray Technologist for over 25 years, and has published three novels and his first full-length poetry collection, How Birds Fly, is the winner of the 2018 Lena Shull Book Award. He lives in Greensboro, North Carolina and works at Cone Health.

Tala B. Shahin – is a first-year medical student who enjoys experimenting with different forms of creative expression—including photography, filmmaking, flower pressing, and versification.

Tesneem Tamimi – is a medical student at the University of Arizona College of Medicine in the Class of 2022, and has been writing in little, worn-out notebooks since the age of 13 as a way to observe human behavior and navigate the different cultures that have shaped her life.

Vanessa Felix – is an artist at ArtWorks, an outreach program housed in Sonoran University Center for Excellence in Developmental Disabilities at the University of Arizona, Department of Family and Community Medicine.

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Beautiful Decay | Jenna Kay