

Narrateur

REFLECTIONS ON CARING



HOFSTRA NORTH SHORE-LIJ
SCHOOL OF MEDICINE
ART & LITERARY REVIEW

ISSUE THREE 2014

Narrateur

REFLECTIONS ON CARING

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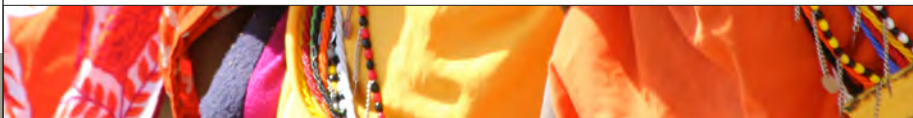


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From the Dean of the School of Medicine

Welcome, readers, to the third edition of *Narrateur: Reflections on Caring*, the art and literary journal of the Hofstra North Shore-LIJ School of Medicine and the North Shore-LIJ Health System. And thanks to all of the contributors to this issue, who once again remind me of the extraordinary talent of those who spend most of their time caring for patients. Reflecting on those special moments that bond caregivers with patients is one of the ways that we learn about ourselves, remember why we chose the field of medicine and continue to build a sense of satisfaction in our work.

This issue will once again allow all of us to share in those special moments and relate them to our own lives and our own identities as caregivers. *Narrateur* is a celebration of the humanistic values of medicine and the incredible importance of the patients who come to us for help. As you peruse this edition, if you were not a contributor, please think of sharing your own talents in future editions of our art and literary journal.

LAWRENCE G. SMITH, MD, MACP

Dean, Hofstra North Shore-LIJ School of Medicine

Executive Vice President & Physician-in-Chief, North Shore-LIJ Health System

From the Editor-in-Chief

This issue of *Narrateur: Reflections on Caring* is dedicated to Branson Sparks, a doctor-in-training who reminded us that the lines between those who heal and those who need healing are often blurred. Branson would have become an amazing doctor. He was diagnosed with peripheral T-cell lymphoma during his first year of medical school at the Hofstra North Shore-LIJ School of Medicine. He died on June 19, 2013. He was 26. Branson's compassion, his brains, his fortitude and his unflinching good sense provide examples for all of us to follow. Our art and literary journal was formed with the first class of our medical school. Branson offered his talents with his camera and his words. He was on our student editorial advisory board. Last year, from his hospital bed, Branson wrote an extraordinarily difficult piece about his illness, but he did it in such a way that it had nothing to do with his illness but instead was about someone whose scars on the autopsy table felt familiar to him.

There are so many poignant stories that appear in the latest issue of *Narrateur*. Without our experiences taking care of our patients, without the lessons we learn, these pages would be blank.

JAMIE TALAN, MPH



Branson Sparks

CRYSTAL KYAW

Crystal Kyaw is a third-year medical student at the Hofstra North Shore-LIJ School of Medicine.

NARRATEUR

The Bee Whisperer

The inaugural class of 2011 was just settling into the new medical school when I went searching for students interested in studying the allergy-fighting effects of raw honey. I have been a beekeeper for decades, tending to four beehives in my back yard on City Island, and I saw an amazing opportunity to exercise my passion for bees on the flower-rich campus at Hofstra. I established two hives in the campus arboretum and prepared to put our local honey to the test.

Five students accepted the challenge. Among them was Branson Sparks, a young man with a sweetness that matched that of the sticky combs that he would come to manage. With his Eagle Scout skills it was easy for him to light the smoker with only one match and dry leaves, to create the billowing white smoke used to calm the colony.

And it was in this management mode that he came to teach us a lesson about the secret life of honeybees. On a weekend in the spring of 2013, a huge swarm of bees from one of our hives took flight and settled into the basement of a Hofstra dorm. They arrived at their new home through a narrow crack in the wall as Hofstra students had just finished finals and were packing to go home for the summer. Grounds security called Branson, who then called me. “What should we do?” he asked. “They want to send in exterminators to take care of the bees.”

“Not much can be done,” I told him. “Once they are settled into a new site it is virtually impossible to get them out. It takes site scout bees many days to arrive at a consensus. Century-old literature says it can’t be done.” I left it at that.

But Branson the Eagle Scout thought through this new problem and came up with a plan that he thought might work. He set up a bait hive, with lots of nice fresh combs of beeswax glistening with honey, right next to their new home behind the brick wall. Bee history said it would not work. But the young man proved the textbook historians wrong. The colony, queen and all, moved into the luxury penthouse apartment. Branson was buoyant. He simply said: “Honeybees don’t read textbooks.”

Was Branson the consummate bee whisperer reading and skill-

fully responding to subtle bee behavior?

A year earlier we had been talking about colony collapse disorder (CCD) and the effects of pesticides on bee behavior. “Sure, honeybees are not indigenous to North America, but is agriculture?” Branson asked. We decided to take this discussion to a summit of small farmers of Long Island, and more than 60 people showed up at the Arboretum Amber Apiary to take part in the conversation. We stood alongside the hives, thousands of bees out flying. There was concern that some human behaviors might spark some rather unpleasant bee behavior – an outright attack – and Branson stood guard at the entrance to the workshop and asked guests whether they had eaten bananas for lunch or had them in their bags. He explained that the banana smell was similar to pheromones liberated by the guard bees at the hive entrance that spark a “cry to battle” signal. Those who had come in contact with bananas that day moved to the back of the gathering crowd, far from the hives.

“Don’t swat them,” Branson warned the guests, many of them children. “They are not those pesky yellowjacket wasps; they are not interested in you and just want to get past and dine at the nearest flower.” We explained to the farmers how neonicotinoid-type systemic insecticides, while they are convenient since they can be applied just once on the ground or on the surface of seeds, can do more harm than good. These pesticides are expressed in the pollen and nectar that honeybees harvest and are now considered to be one of the major factors in CCD; their use has been banned across Europe. A gentle Branson take-home message was this: Farmers need honeybees a lot more than convenience.

The next day we learned there was a guest in the group who resonated with Branson’s sweet ways. Isabella Rossellini, the actress and daughter of Ingrid Bergman, had a lifelong fascination with bees. She would understand another Bransonism: How sweet they can be when shown due respect. Another local celebrity was the CEO of the Friends of Sands Point Preserve, Jean-Marie Posner. She asked Branson whether it would be possible to set up an apiary at the preserve. SOM student Matthew Katz and his mother, Edith, known on Sands Point, helped implement and run the project.

Branson set up workshops at the preserve. He helped chil-

dren get over their natural fear of the cloud of flying, stinging insects. It was important for Branson to achieve perfect alignment of every part of the hive, brood, frames, inner cover and supers. Branson was honored with a Preservers’ Award of Distinction at the Gold Gala of the Fifth Annual Preservers Celebration on May 4, 2013, and a tree was planted at the apiary and named for him.

Our study on the healing effects of local honey is just now taking flight. Honey that Branson helped harvest sits in perfectly aligned jars, ready and waiting for patients to self-administer just before the spring 2014 pollen allergy season kicks in. It is hoped that the natural, local, raw honey, which contains these pollens, will serve as an oral desensitization nutraceutical agent to gently warn the body’s immune system of the imminent arrival of pollen and help prevent any overreaction that might ensue. We will be reminded of Branson’s passion for organization and process, and the magic of overturning lessons in textbooks.

Patrick J. Gannon, PhD, is a professor and chair of the Department of Science Education at the Hofstra North Shore-LIJ School of Medicine. He is also a beekeeper.



Elmina Castle

THOMAS SCHOENTHALER

Thomas Schoenthaler is an advanced clinical experience (ACE) manager at the Hofstra North Shore-LIJ School of Medicine.

NARRATEUR

Opa

Tell me how you remember
that story, the one you told me last Easter
about postwar Europe and voyaging across
the ocean, the one where they said to hide
where you were from but you didn't
and ended up coming here in 1950.

Tell me how you remember
each home you've ever built, how you
caught the sun in your glass of water,
drinking its last drops of light, working
until your sweat returned to the sky.

Tell me how you remember
the town you sculpted with your bare hands,
the canvases you painted in your spare time,
the poems you inscribed in each breath.

Opa, I remember it all.

Nolan Meditz is a student in the MFA in Creative Writing program at Hofstra University. Born and raised on Long Island, he uses his words to illustrate his connection to home and family.

The Badge of Courage

There is a moment of silence. It is the first that I've enjoyed for a long while. Unpacking the last of countless boxes overfilled with the artifacts of over 20 years of clinical practice, amidst the many photos, cards, and letters of gratitude, I come upon a black button. Emblazoned in white across it is the simple message: "SURVIVE."

My thoughts drift back to the day that I was awarded this precious, well-worn medal.

A cold November wind cut through me like a knife as I marched quickly into the medical center. What a relief it was to cross its threshold, and yet what a struggle. Awaiting me on the tenth floor were my troops. Each was unique, but we were bound together by our struggle with a common enemy – a fearsome enemy, as elusive as it was deadly.

Arriving on the battleground, I immediately locked into the mortal combat that had become our daily ritual. Greeted by the brave smiles of nurses, medical students and residents, I commenced the daily assault upon the enemy.

Standing beside the doorway, the student began his report: "M.G. is a 37-year old Caucasian man with late-stage AIDS and CMV retinitis. Ophthalmology confirms progressive disease on gancyclovir. He complains of weakness. Hemoglobin is down three grams over the last 48 hours. We'll have to transfuse him three units. What else can we do?"

"Let's go inside and have a look," I said. In we marched to meet our wounded ally. "Doc, get me out of this stinking rat hole. This is the worst room I've ever had!" His greeting was as anxious as it was hostile.

"Good morning, Mr. Gray. I'm Dr. Cervia, the ward attending. How can I help you?"

"You can get me out of this lousy room and off of this damned medicine," was his firm and swift reply.

After a pause, I said, "You have become quite anemic on the gancyclovir. It is likely that you will need to receive some blood today. I agree that this particular medicine does not appear to be helping all that much. Moreover, your body isn't tolerating it very

well. I would recommend a different drug, called foscarnet."

Far from content with my assessment of the battlefield situation, my ally begged to differ. "Doc, with all due respect, you can take all of this medicine and shove it somewhere. Just get me out of here."

"I'll do all I can," I replied. "I'll also return later so that we can talk some more," I added, as I retreated to the relative safety of the hallway. I would need time to gather intelligence before our next skirmish.

After rounds were completed, I returned to speak with my patient. I learned a lot about Merlyn Gray that morning. Upon winning some of his confidence I learned that he was an artist; a painter, to be more precise. The progressive loss of his sight to cytomegalovirus retinitis, a late-stage complication of AIDS, was devastating. As we sat in the trenches together he confided that his fear of losing his sight was worse than his fear of dying. Sadly, the realization of both these fears did not appear distant.

"The gancyclovir made me anemic. What is this new medicine going to do to me?" he asked.

"It is not certain that the foscarnet would help slow the progression of your visual loss, but it is also far from certain that you would suffer any adverse events on it," I explained, attempting to sound encouraging. "Nevertheless, I must tell you that foscarnet has been associated with renal insufficiency, that is, kidney failure."

"Well, that's just great, Doc! First, you make me anemic, and now you want to wipe out my kidneys as well! Why don't you just leave me alone, and let me die in peace?" Merlyn fired.

"I don't believe that we should give up without a fight. You aren't dying today. Why don't we give the foscarnet a try?"

"Just get out, Doc. I don't want to get angry, and you are making me angry. Now, just please disappear."

I made my slow retreat, vowing to return again the following day.

I did indeed return the next day, and for each of the seven days after that. With each offensive, Merlyn expressed his anger at and

displeasure with his room, the hospital, the food, the nurses, the residents, the students and me. Upon being dismissed by Merlyn again on the eighth day, I reluctantly proposed an exit strategy. If the patient was so displeased with us and so unwilling to accept our care, I would arrange a transfer for him to an institution of his choice.

My shock must have been evident the following morning when upon my arrival on the field of battle I was met by a warm smile and a hug from Merlyn. “Doc, thank you for putting up with me,” he said. “Thanks for taking all of the abuse, and never giving up on me. I want to live. I will give the foscarnet a try.” Rarely in my young career as a physician had I been filled with such joy. I lamely attempted to hold back a tear.

Later, in the hospital lobby I noticed a booth erected to honor the nascent World AIDS Day. As I passed, I saw the black button with “SURVIVE” in white. I purchased it and later that day awarded it to my brave comrade. Tears filled Merlyn’s eyes as I pinned it to his hospital gown.

Two weeks later, another small victory. Merlyn’s CMV retinitis appeared to be under control. Foscarnet had been the weapon and it appeared to have won the day. Merlyn was stronger and would return home, receiving the drug as daily maintenance therapy. I warned my ally that we would have to continue to be on our guard, as the AIDS and CMV were deadly foes, and foscarnet a hazardous weapon.

Merlyn, in street garb for the first time in over one month, thanked me as he marched off the battlefield. He broke out the black button from his knapsack and with an embrace pinned it on the lapel of my white coat. Then he disappeared into the elevator.

Through the many struggles over the years, I have kept this badge of courage in view. It has been a lasting reminder of the persistence and valor that are the essential elements of victory on any of life’s battlegrounds. Indeed, it is fear itself – camouflaged by anger – that is the real enemy, while kindness and patience are our most powerful weapons.

Joseph S. Cervia, MD, is a clinical professor of medicine and pediatrics at the Hofstra North Shore-LIJ School of Medicine, and an attending physician at the Center for AIDS Research and Treatment. He is also the regional medical director of HealthCare Partners.



Determination

BENJAMIN STUART

Benjamin Stuart is a first-year medical student at the Hofstra North Shore-LIJ School of Medicine. His work has been featured at the Fisher Museum of Art in Los Angeles and on the Ontario Ministry of the Environment website.

The Promenade

(Marty and Charlie Rosto, brothers, 80 and 83, sit in wheelchairs in front of an assisted-care facility called the Promenade. It is a chilly fall day, and their lower halves are covered with blankets, each with a big P on the front, signifying the Promenade. Evelyn, a beautiful woman of about 75, sits alone on a bench opposite them. She is covered with what looks like a hand-knitted afghan.)

CHARLIE

You look like a big dope with that big P on your blanket, kid.

MARTY

You know, at this age get over the big brother stuff, already. You're only 4 percent older than me.

CHARLIE

You're ridiculous with your numbers. How do you know it's 4 percent, and who cares if it's 4 percent?

MARTY

That's why I saved your backside in the candy store. You were an idiot with numbers. You made a great egg cream, but with numbers you were an idiot.

CHARLIE

You made a lousy egg cream

MARTY

Yeah.

CHARLIE

What's so hard about making an egg cream?

MARTY

Like a lot of things, there's just sort of a way to do it right.

CHARLIE

Yeah, I guess.

MARTY

You remember Greta, who came in every day to buy the *Post*?

CHARLIE

Yeah, sure.

MARTY

I wonder where she is now.

CHARLIE

Dead.

MARTY

Dead?

CHARLIE

Just guessing.

MARTY

She was beautiful.

CHARLIE

Yeah.

MARTY

I always made sure we had enough *Posts*.

CHARLIE

You know, they say a guy in a place like this does pretty good.

MARTY

Yeah? I don't see it.

CHARLIE

Me neither. Maybe it's the wheelchairs.

MARTY
Yeah.

CHARLIE
That woman across the way?

MARTY
You mean Evelyn?

CHARLIE
You know her name?

MARTY
Sure.

CHARLIE
I met her at Bingo.

MARTY
The Tuesday night movie. *On the Waterfront*.

CHARLIE
Hah! You, you never “coulda been a contendah!”

MARTY
No.

CHARLIE
She reminds me of Greta.

MARTY
Who does?

CHARLIE
Evelyn.

MARTY
Yeah, me too.

CHARLIE
I don't remember how.

MARTY
Me neither. How what?

CHARLIE
How to start talking with a woman.

MARTY
Me neither.

CHARLIE
Why, you want to?

MARTY
Sure. She reminds me of Eva Marie Saint.

CHARLIE
When they called out “B16” and she had it, I was hooked.

MARTY
I don't know how, Charlie.

CHARLIE
Me neither, Marty, I don't know how. I don't remember.

MARTY
Yeah.

CHARLIE
It's the right amount of seltzer.

MARTY
What?

CHARLIE
That makes a perfect egg cream

Burton Rochelson, MD, is chief of obstetrics and maternal fetal-medicine at North Shore University Hospital. He also is a playwright.



Sunset Cruise on the Grand Canal

STEVE RUBIN

Steve Rubin, MD, has been photographing the world since his first year in medical school. He is vice chair of ophthalmology at North Shore University Hospital, professor of ophthalmology at the Hofstra North Shore-LIJ School of Medicine and a Society Master at the medical school.

The Anatomy of Love

Love is not blind.
 It is a tireless voyeur, and you are its favorite subject.
 It sees your eyes blinking behind a thick set of glasses;
 It feels the cracked valleys of your thirsty skin, smooth in youth,
 And travels down these beloved paths
 With soothing soaps and lotions.
 It hears the faint rasp in your throat, quieting your booming laugh to a whisper,
 And it knows that it simply must listen more closely.
 Love is there to steady your elbow when your legs betray your insistence
 That everything is fine, you just felt dizzy for a moment –
 And it is sitting beside you in an uncomfortable chair when a moment
 Stretches into weeks.
 Love becomes your body when yours refuses to be –
 It shares its steps with you, sure where yours are labored,
 And it coaxes your tired mouth to open and swallow.
 Love takes inventory of every tube, every wire, every piece of gauze
 That you wear like a shroud, and it remembers how to make you feel free
 With a smile, a touch, and that picture you've kept in your wallet
 All these years.
 As love holds your hand for the last time for a long time,
 It will know that it has never loved anyone more beautiful.

*Jennifer Derenthal
 is a unit clerk on the
 Special Care Unit at
 Syosset Hospital.*

Welcome

just push hard on the door, careful the screen is ripped
 I put my head through it the last time I came home when I lost my balance
 well I did forget to use my cane when I went for the mail
 and of course I forgot to put on my splint which didn't help
 but all is well at home
 no problems no questions no concerns
 keeping on keeping on
 trying to remember to do my stretches and exercises
 didn't they tell you that I couldn't find a ride to therapy any more
 didn't they tell you I had to change my insurance
 didn't they tell you I forgot who I was supposed to follow up with
 that's okay, I'm feeling fine, keeping on
 no I didn't have my meal yet, the young lady hasn't stopped by
 but I have some ramen noodles ready to boil, some sardines too
 can I offer you some water or perhaps some toast and jam
 don't worry, I've been watching my sugar by eating the same things
 remember how I was having that pain down my shoulder and hand
 well it stopped a while ago, but I stopped using that hand too
 and because my balance is bad I stopped taking those stairs
 it's much easier to lay down on the couch and bathe in the sink
 oh, it's so good to see you after all this time
 you know I wouldn't have done this well without all your help
 are you sure I can't offer you a chair, let me move the boxes
 you wouldn't mind moving a few for me anyhow over there.

*B. Allyn Behling-Rosa, DO, is a
 third-year resident in physical medi-
 cine and rehabilitation in the North
 Shore-LIJ Health System.*

How My Grandmother Eats Dinner

After Kate McGargle's "I Eat Dinner"

The first night she pulls out some chicken,
two pieces. Gets as far as the oven and turns

to put one back. She chops some iceberg lettuce
and for once doesn't put the tomatoes in a tidy pile

off to the side. She likes how they look
scattered in the pale green leaves. She only uses

paper plates and plastic forks now. Nothing
to wash. Nothing to keep her from time

that is hers and hers alone. She has washed
her fair share. There is nothing to wipe from a chin,

nothing to feed anyone but herself. She eats slowly
and the house is too quiet. The medications stand ready,

and she tries not to look them in the eye. They are
a talent that no longer matters. Sixteen, she thinks.

She was sixteen the last time she ate a meal
without him. She sits at the side of the table,

even though they no longer need space at the head
for the wheelchair. Tells herself she prefers

the view from this angle. Tells herself
it will be easier now. She eats an Entenmann's doughnut

for dessert. Then she eats another. She thinks:
yes, I must have been underwater all these years.

No wonder my need to gulp for air, the voice in my chest
that says up, up at all costs, my lips pinched shut.

No wonder I am floating now, belly warmed by the sun.

Emily Kagan-Trenchard is the director of web technology for the North Shore-LIJ Health System. With her master's degree in science writing, Emily explores the intersection of science, health and society in poetry and prose. She has been published in numerous journals and anthologies.

Finding My Calling in Kashmir

October 8, 2005, was a beautiful, sunny day in Islamabad. Sleep was still in my eyes when I felt my world shake. I heard a “zzzzzzzooooooooommmmm” sound caused by the vibration of everything in the room, especially the glass. A bomb came to my mind. But why didn’t I hear the blast? Why just waves and shock? Suddenly I knew. “Damn, it’s an earthquake! Run, run, save your life! Run before the building collapses!” I screamed inside my head. The demon was shaking the building with rage. “Hassan, say the Kalima before you die.”

In a flash I was outside the building, where I found many people who had also fled their homes. I was excited, nervous, shaky and scared. Thankful that I was alive, I had other thoughts: “What if I had died like this?” or “What if my father or mother or someone else has died?”

I tried to call my family to tell them that I was fine, but I could not reach them. Then I vainly attempted to reach friends. Frustrated, I went back to the room and turned on the TV. The news was dominated by coverage of the earthquake. Reports said it had registered 7.6 on the Richter scale. Soon, I heard ambulance sirens and fire engines.

It was the next day that news of the devastation in Kashmir started to filter in. Early reports said a few people had died there. Then it grew to a few dozen, then a few hundred, then a few thousand. After a few days the government, media and public realized the true extent of the tragedy outside Islamabad. The death toll was estimated to be 80,000.

Many voices appealed on television and radio and in newspapers for help. People were giving donations – money, food, clothes, blankets, utensils, almost anything. Private organizations and the government were sending aid. Volunteers were on their way. I had been working as a physician in Lahore and preparing for my American medical license exams, but I put all on hold and applied for extended leave to go to Kashmir. It took a week and many calls, but I got a position as a volunteer doctor in a camp for displaced persons near the epicenter of the quake, where the highest number

of deaths had been recorded.

I did not realize it at the time, but the experience would change the trajectory of my professional life and transform me into a more compassionate, caring human being.

Our team included my best friend from medical school, Khawar, his brother and a medical assistant. We left Lahore riding in the back seat of a small Toyota van, but it was not smooth sailing.

Winding around the hills of Kashmir, we all began to suffer-motion sickness. When we reached Muzaffarabad, the capital of Pakistani Kashmir, I got out and immediately lay down on the side of the road – the trip had sucked the life out of me. The final leg of our journey was a ride to the top of the mountain in a small pickup truck with us hanging onto a metal bar outside the vehicle – no one dared sit inside the cabin.

When we finally arrived at Ihsas (Care) Relief Camp in Meera Tanoolian, we were warmly received by the camp leader, Ijaz, and his fellow workers. After a good night’s sleep, I felt fresh the next morning despite the grueling 12-hour journey.

We selected the place for the clinic, and after erecting a makeshift tent of bamboo and tarpaulins, we put in some necessary furniture – closets, couch, chairs and a desk. It had been almost three weeks since the earthquake, and most of the surgical emergencies had been taken care of by nearby medical staff or by nature. The results were not always desirable.

Our patients had pain, aches, fever, infections, scabies, old wounds from surgeries that needed a change of dressing or a refill of medication. As we were staying in the same camp as the patients, they would often come at night. We saw everything from pregnant women to neonates, chest pain to skin rashes.

Meera Tanoolian was only a few miles above Muzaffarabad. After a few days we decided to hike down to see the damage. It was a ghost city; not a single structure was left standing. One sight that broke my heart was the rubble of a school where over 200 children had died. We could see books and pencils on the ground. What was once a playground was now a graveyard. Once in a while we could smell decomposing bodies.

While in the city we visited different medical tents and talked to treatment teams. This networking helped us become aware of the resources available. We met doctors at an Islamic camp who ran a huge hospital to which we had transferred a few patients. The Red Cross had a well-appointed camp inside the cricket stadium, and we referred a few of our patients there as well. The U.S. camp – which had the only burn unit – was run by armed military personnel, unlike those of Arab and African countries and Cuba.

Psychologically, most quake victims were fearful of the future. They had lost loved ones and most, if not all, were stripped of their worldly possessions. Many of them were showing signs of acute stress disorder, anxiety and depression.

Trucks full of food, blankets and clothes would come every second or third day. Ijaz's heart was big, and he would distribute everything quickly. People standing in line would say what and how much they needed for their families and he would see they would get it. "Let's spread it to the deserving," he said. "I do not want to keep it in my storage room. It's not mine. I want to be quick, efficient and honest in delivering it to the people who need it. Let's do it now."

We were living a very basic life. We had the same menu for a month – boiled rice and lentil curry at dinner, parathas (pita bread fried in oil) with an egg, sunny side up, for breakfast and some boiled vegetables at lunch. I put on weight because of an excess of carbohydrates. People were happy to get whatever they could and did not complain.

It got very cold at night, and stoves were not allowed inside for fear of fire. Khawar had a cellphone with a camera and music player, and he had recorded some songs on it. I remember one was "Sexy Mama" by Bombay Rockings. It was the only music available and I probably heard that song 3,000 times.

I wanted to explore the area and see the destruction first hand before returning home. A couple of times I hitchhiked to the city in the morning and spent the whole day there while Khawar ran the clinic.

The saddest stories were the missing people. Were they dead, alive or victims of human trafficking? I met the mother of a teenage girl who had disappeared from the camp two or three days

after the earthquake. "Where is my daughter?" she cried.

There was a high court justice who believed his elite status in town meant that he should not stand in line for food. He was starving.

In a step toward recovery, UNICEF established a school and recruited a dedicated staff of volunteers from the camp to run it. Kids were kept busy studying, learning and having a good time together. The school provided books, notebooks, stationery, coloring books and other materials to keep them busy physically and mentally. Because of poverty in the region, many had never seen a coloring book or a box of Legos in their lives.

For all of us working in the camp, the days were very short and the nights were very long, but the time went fast. Soon, the next medical team arrived from Lahore to relieve us.

The experience in Kashmir left a lasting imprint on me. Yes, it is important to treat broken bones and infected wounds, but there is also a need to take care of wounded psyches. Most of the earthquake victims I met also needed holistic treatment that included bio-psycho-social rehabilitation.

When I returned home to New York, I experienced a very strong vision, a calling, after which I decided to change my career path from medicine to psychiatry. I believe that as a psychiatrist I can do a noble job of helping people worldwide, wherever help is needed, in time of disaster.

Hassan Majeed, MD, born and educated in Pakistan, is a fellow in child and adolescent psychiatry at LIJ Medical Center. He is involved in human rights activities. He also runs marathons.

The Old Man and His Dog

“You can’t bring animals into the hospital!” the social work supervisor scoffed. “It’s against the rules.”

Forty odd years ago, I was a medical social worker, in my early twenties and in my first job at a New York City hospital that prided itself on state-of-the-art medical treatment, research and patient care. I was also a proud member of the flower generation that not only questioned rules but chose to create its own rules for a new social order that made sense.

“My patient is dying and wants to see his dog for the last time.” I stood my ground. The rule was unreasonable and unfair and there had to be a way.

The patient, an 85-year-old gentleman with metastatic lung cancer, had no family and lived alone in a Queens apartment with his dog, Lucky, a mutt he had rescued from the pound many years earlier. Bedridden and attached to multiple tubes and lines, he was barely able to breathe, let alone voice his last wish. But he did voice it when I asked him. Since I was new to the job, three months new, in fact, I was unfamiliar with how to talk to someone who was dying. So, in my naiveté, I asked the obvious question: “What do you want in the time you have left?”

“I want to see Lucky for the last time before I die.” He was honest and direct. He seemed to know his time was short. I felt I had no choice but to make the meeting happen.

I found out that Lucky was staying with my patient’s neighbor in the same building. I called the neighbor and made arrangements for him to bring Lucky to the hospital lobby the next morning. Looking back, I must admit that it was sheer nerve that brought me back to the social work supervisor that afternoon to insist that we bend the rules. “But I can lose my job for this,” she said weakly. I didn’t back down.

When she finally agreed to help, I think, in her heart, she enjoyed flouting the rules, and I’m certain she relished her role in helping to make my patient’s wish come true.

When Lucky entered the hospital lobby the next morning, my patient was waiting for him. The dog immediately jumped into his lap. Here was a wizened old man whose pale face and moist eyes

lit up with joy at the sight of this mangy dog. When Lucky licked his face from top to bottom, I knew it was medical care that needed no script.

The next day when I showed up to work I learned that the old man had died overnight. Now, without question, I knew I had done the right thing.

This was a defining experience for me, and it has led me on a lifelong journey working with those who are dying and honoring their last wishes.

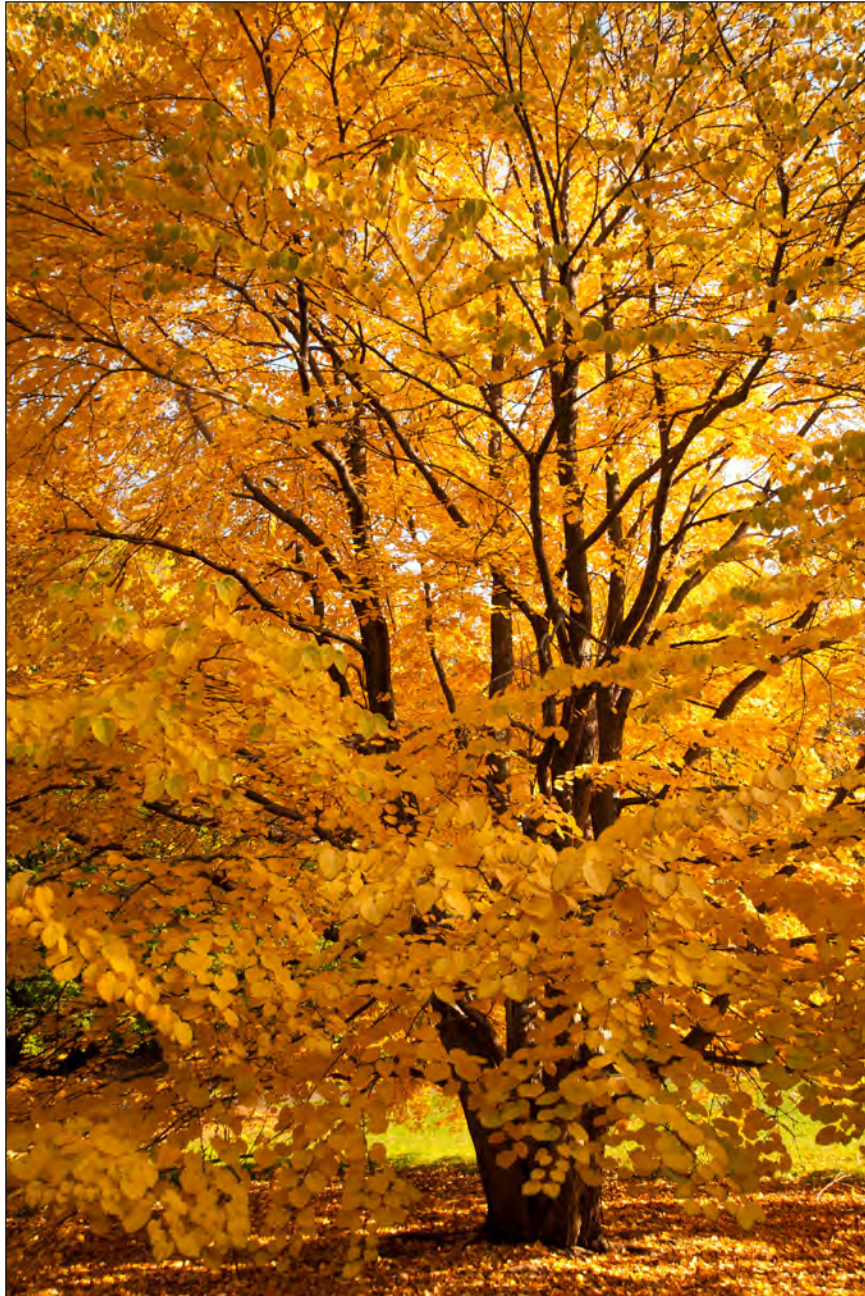
Heidi Mandel, PhD, is a social worker specializing in hospice and palliative care. She works with patients at Lenox Hill Hospital’s Outpatient Infusion Center.



Felicity

CARLA PODGURECKI

Carla Podgurecki, MD, is a second-year family medicine resident at Glen Cove Hospital.



Golden Tree

MARIA RUGGIERI

NARRATEUR

*Maria Ruggieri, PhD, is a scientist at the
Feinstein Institute for Medical Research.*

Betty

Betty was the reason I went into the field of palliative care. “Better check my kidney,” she used to say. She’d just celebrated her eighty-seventh birthday, but she had clicked off another event for half a century. “It’s the only one I got,” she said, reminding me again. “And be quick about it. I have to take the girls to lunch. Otherwise, they would sit around and feel sorry for themselves. I have to keep them moving.”

Betty had the grit of a soldier. Her husband had died before she lost a kidney and she had been left to raise their only child, a son. She was now maintaining her independence in an assisted living community nearby. When I saw her on the roster for her routine visits, lightness came over me. She brought that out in people, Betty did.

One early morning, 20 minutes before my shift was over, the pager went off. The beep droned in my ears. It was summoning me to the emergency room. I prayed for a mistake, or something that would take, well, another 18 minutes.

“Hello, this is Dr. Tsukanov. You paged?” My voice was unenthusiastic.

“We have a patient of yours, Betty Wilson. She seems to have pneumonia. She came in with a productive cough, a temp of 101, and her blood pressure is very low. She may need pressors and to go to the unit. You had better come right away. Room 22.” His voice was growly and tired.

Caring for Betty had always been easy. Now, my heart raced as I made my way like a speeding train to Room 22. There she was, stretched out on a mattress, pale and weak and short of breath. Her eyes were closed, but the air that I pushed into the room with my frenzied entrance made them open. She looked at me. Even her smile was weak.

Her numbers did not look good. Persistent low blood pressure despite multiple fluid boluses, high white count and fever with a chest x-ray that screamed pneumonia. Worse, her one good kidney was failing.

At that point in my career I had never had the death talk. It was not one I wanted to have with Betty or her son. I was angry that

medicine had nothing left for Betty. I was sad that I was the one holding that empty bag of tricks.

Betty's son, his wife and their children entered Room 22. I had met him many times over the years, and he read the half-smile on my face with relief. He was probably thinking that she'd always walked away when I was around. This time, I thought, he'd be wrong.

"Can we talk in private?" I asked

"The prognosis is not good," I said, and slowly, carefully, I selected the right words to let him know that his mother would probably not make it through this surprise battle.

"Doc," he said, "I understand what you're telling me, and it sounds bad. I know my mother would not want to be tortured. She deserves comfort. Can we make her comfortable and allow her to go peacefully? I don't want to kill her, but I don't want her to suffer, either." His voice sank into his throat. "Doc," he said, "she was all I had growing up. I need to do what is best for her. What would you do?"

What would you do? The line choked my brain like a clogged artery. I knew Betty well enough to know that she did not want to be tortured. I also knew that there was nothing that would save her anyway.

"We're not killing your mother," I said. "We are preserving her dignity and grace." I stayed with them until she was transferred to a private room.

Betty settled into the bed. She knew that her end was coming.

She did not look scared, not at all. She was surrounded by her family, and three generations found strength just to love. I had never imagined that death could be accompanied by such beauty and dignity. Sometimes, I learned that day, there is no more need to focus on the vital signs or the lab values. There is no more fight, but just one final good night.

Jessica Tsukanov, MD, is currently the chief fellow in palliative care at North Shore University Hospital and LIJ Medical Center.

The Girl at the End of the Hall

I saw her for the first time last week.

I was in her room for just a few moments. She had just barely woken by the time the surgery team had completed its daily pre-dawn ritual of poking and prodding and scurried out the door. She seemed unfazed by the intrusion of yet another drove of white-coat-clad strangers.

Sitting in the resident room today, we talked almost voyeuristically of her ever-changing, "quite interesting" working diagnosis. It has progressed from bad to worse and now the fear is that the girl who came here with a headache and some dizziness may have metastatic disease.

Sixteen years old. A few short months ago she was on a soccer field, her biggest concern maintaining a 2-to-1 lead. A quick survey of her room had revealed a photo of her sporting a warm, captivating smile and holding a soccer ball adorned with the signatures and well-wishes of teammates.

It doesn't seem possible that the girl I had seen – now too weak to walk down the hall without assistance or to get out of bed some days – and the happy girl in the picture are one in the same.

As I walk down the hall to see another patient, I catch her eye. To her, I am likely just another stethoscope in the crowd, just another of the hundreds of doctors she has seen in the past weeks. Her face has a look of chronic exhaustion and near-defeat. I've started to wonder if she still remembers what it feels like to smile.

She has achieved a celebrity status she never asked for. In the name of education, her misfortune has become a focus of daily conversation and an outlet for morbid curiosity.

Our gaze is broken and I go about my day.

It later struck me that despite the fact that we had no relationship beyond that fleeting stare, I had learned some of her most intimate personal details. I wonder now whether I may have learned her diagnosis – and its potentially fatal prognosis – hours, perhaps days, before she did.

Jonathan Mallen is a third-year medical student at the Hofstra North Shore-LIJ School of Medicine.



The Future

VU TRAN

NARRATEUR

Vu Huy Tran, MD, is an emergency medicine physician at Lenox Hill Hospital.

ISSUE THREE 2014

That Warm Hand

I've had a wish these 20 years
to meet and thank those rescue workers
who pulled me from the plane,
who treated me as if my neck,
my back were broken.

They were! Someone stayed
and held my hand. Let me tell you
this was so important
to a frightened woman.

I'll never forget the comforting,
the reassuring voice,
and that warm hand.

*Anonymous Survivor; Avianca Plane Crash,
Oyster Bay Cove, Long Island, January 25, 1990.*

Written 20 years after the crash.

*Victor Fornari, MD, is
director of child and ado-
lescent psychiatry at North
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tal, and Cohen Children's
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pediatrics at the Hofstra
North Shore-LIJ School of
Medicine.*

The Passenger

I have now become a blinding reflection
From the oldest rainbow
I am the dark cobblestone road
With no end in sight
Just a blank stare in the far horizon
Of my circular bed
I am the canvas framed in electric contraptions
That constantly declares battles
To keep me on this side of the fence
Which knight will joust the hardest
To take a tattered flag into the darkness?
The clouds dangle from metallic branches
That deliver painted spiders in my veins
My skin is so thin
My tempo is so slow
My heart can't keep the cadence
Of the dancing troubadour
The haloed doctors wear long-nosed masks
With knowledge trapped in long-necked flasks
Their basic rules do not apply
When two coins cover your eyes
The time has come for me to row
Just move my arms
With the gentle caress of the whip on my back
No rhythm
No rhyme
No reason
I won't get too far

Jorge D. Nieves, MD, is in private practice at Forest Hills Pediatrics.

Grandma from Hicksville

Grandma from Hicksville, that's how we referred to her. It was three words to differentiate her geographically from my father's mother, Grandma from Astoria. Grandma from Hicksville always wore a pastel sweater no matter the time of year, with her short white curls landing right at her neck. Her skin was cashmere soft, without a wrinkle on her face. Spending the day with Grandma from Hicksville always meant a new toy at the end of the day from the local drug store. It meant being able to tell my mother I ate all my vegetables although actually my grandmother had pushed them lovingly off my plate and onto the floor for her Irish terrier to eat. It meant watching "Beavis and Butthead" at night when my parents went out. It meant eating Apple Cinnamon Cheerios for dinner and bowls of ice cream so big I was never able to finish. Time with Grandma always meant doing things mothers would not approve.

I was six years old when I first heard the word Alzheimer's. I was at my grandmother's house – in Hicksville, of course – and had just been outside kicking pebbles at cars. They were too small to inflict a scratch, but an old woman in a silver car had stopped and shouted at me. "That could really hurt someone!" she yelled, and then she drove off. When I burst through the door, my face must have been red because my grandmother looked at me and fixed me a glass of juice before she headed upstairs.

I sat quietly at the round kitchen table, holding the glass with my two hands, slowly sipping. My mother said something about Grandma starting to forget things, like directions and dates. My father, a doctor, mulled it over and offered an unofficial diagnosis: "It could be the beginning of Alzheimer's," he said. My mother sat down heavily at the table with me. I had no idea what that word meant. I had just escaped a scolding, so I was perfectly content just sitting there with the glass between my hands, smiling.

Within months of that day Grandma from Hicksville became Grandma from Hampton Bays. I don't remember too many details, but it was almost as if she was not there one day and somehow materialized the next. My parents put an extension on our house. I recall hiding behind the newly poured concrete foundation throwing tennis balls with my brother at the window of our living room. She

often sat in a chair right by the window, and the banging always made her push herself up with the arms of the chair to see what was going on. She would see us but would never fully comprehend that my brother and I were making the racket.

Sometimes my grandma went outside. My father once found her on the side of Montauk Highway, walking by herself. When he stopped the car, she explained that she was trying to get to church. Getting out of the house was a frequent event in those early days, but it seemed that she only would leave when something made her angry. And sometimes I was the one who ticked her off. Her aimless wandering frustrated me, not to mention her habit of walking around the house without her clothes. She came to be someone who would snap at me for no apparent reason, and sometimes my frustration would boil over into a rant.

Being the young kid I was, I never once thought of her as the person I had known; sure, she looked the same, but her eyes were different. Her eyes were empty, fixated on nothing. Her lower jaw hung heavy. There was always the blank look, always the indeterminate stare, and always those vacant eyes.

When she did get outside unnoticed, I would track her down and tell her that her best friend, Joan, was on the phone. Once she heard that name, she would turn right around and come back inside the house. I usually held her hand so she'd know I was there, and also so I would not lose her again. Once inside, I would lead her into her bedroom and turn on the television. My parents never had to know that she had been outside unaccompanied for some fresh air that day.

Finally, Grandma forgot how to open doors, and my parents had to move her into a nursing home. The place was so depressing; bare walls and other zombie grandmas weren't something I particularly enjoyed seeing on my weekends off from school. But it meant a lot to my mother, so I went along.

I was a senior in high school the last time I saw my grandmother. At that point, she had lost most of her teeth because she was unable to rinse or spit, her arms and legs and fingers had begun to curl inward because of the changes in muscle density and she was

losing weight, a lot of weight. But she still had her same great skin. Despite all she'd been through the previous 10 years, her skin was nearly wrinkle-free. She still had that youthful face, with the same distinct cough when she had something in her throat. I wanted to sit her up and shake her, to scream at her: "Is there anyone in there? Can anyone hear me?" I wanted her to sit up and talk to me, to tell me she understood why I would get so frustrated with her when she lived with us, to understand.

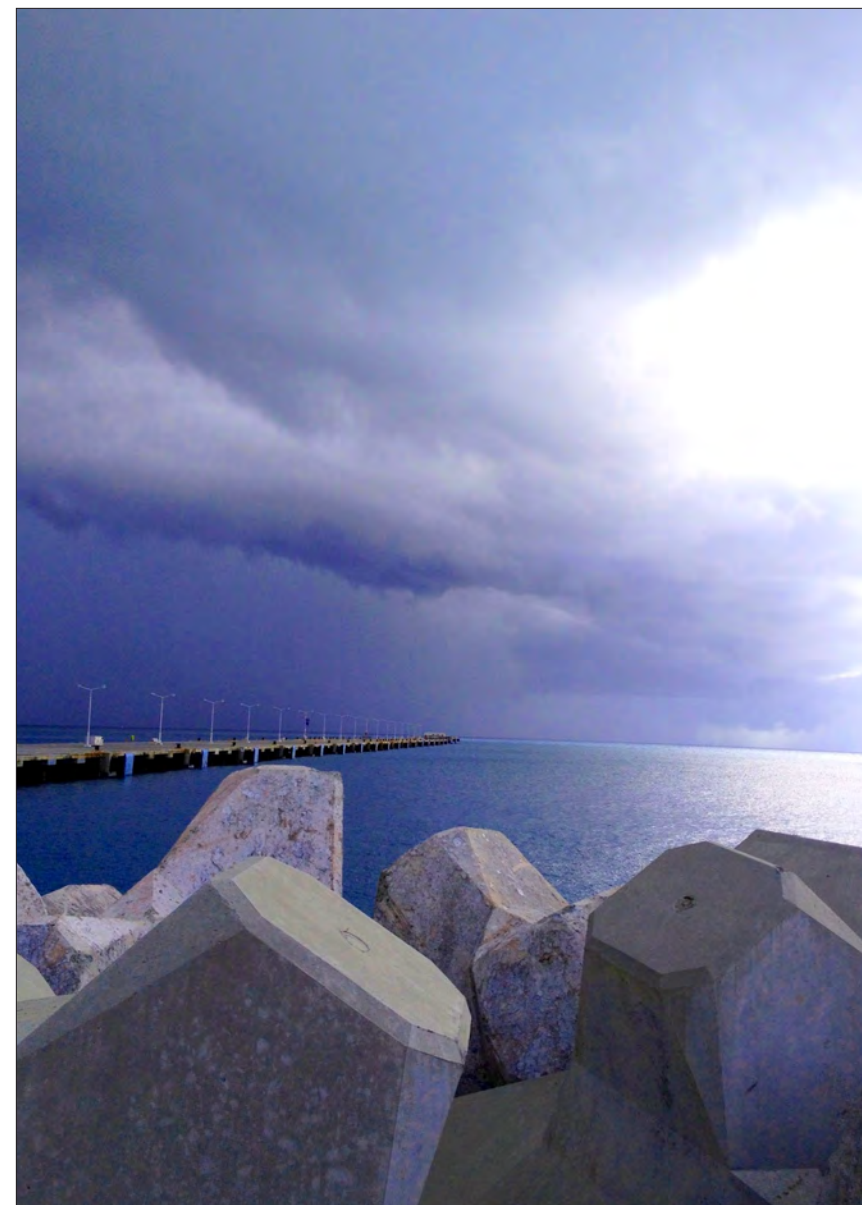
We sat there for a few hours, and my mother talked as if the decade had been kinder to my grandma. She still called her "Ma" and asked her if she wanted what was on her tray. When the nurses wouldn't, she made sure to turn her over to avoid bedsores. I'll never know if she understood when she was told that I was going away to college, or that my brother had just gotten his black belt, or even that my little cousin had just received his first communion. But she was told, as if nothing had changed. Some people believe that pretending nothing has happened helps. Maybe they think this will change the circumstances, or help the person hold on to whatever might be left. Maybe they believe that there is more dignity in pretending.

Throughout my medical training, I thought about Grandma from Hicksville. When I read legal cases about the right to die and brain death and the debates about what constitutes a life, I would think about her.

Sure, my grandmother was breathing on her own, but was there anything left of the young girl she was, the wife, the mother, the grandmother? Was she alive in the living sense? I had long ago said goodbye to the grandma I knew. So much of her had been lost in the decade since I first heard the word Alzheimer's. I remember the last time I saw her. We knew she was dying, according to the strict definition of the word. But her memories were long gone and her words had evaporated. All that was left of Grandma from Hicksville was her breath. And soon, I knew, she would lose that, too.

Daniel Bulanowski is a third-year medical student at the Hofstra North Shore-LIJ School of Medicine.

NARRATEUR



Caribbean Breakers

MARYBETH WRIGHT

MaryBeth Wright is an advanced clinical experience (ACE) manager at the Hofstra North Shore-LIJ School of Medicine.

Tipping the Scales

It was over two years ago that I submitted my application to medical school. My goal was to make sick people better, but I was anything but the picture of health. With a BMI of 35, I had long ago tipped the scales at well over what a physician would call a healthy weight. Yet, there I was, planning a career in which I would tell others how to be healthy. I knew there was something inherently wrong with the situation; I felt it every time a school asked for my picture in advance of an interview, or I talked with other students who were applying. I believed they had the advantage over me simply because they did not look like me. They knew how to stay healthy.

Trust me when I say it did not happen overnight. As a child I was “skinny as a twig,” as my mom always said. At five years old I was actually underweight – an active kid with picky tastes. Somewhere, something changed. By the time I reached middle school I was the heavy kid in the bunch. Of course, I felt the weight in more ways than one. Others in my life at home and at school reinforced that I was now different. I was now no longer the norm. From then on it just seemed to continue, and by the time I was in college I had put on the freshman 15 and then some.

My weight held me back in many ways. It held me back from being taken seriously in many avenues of my life and from being able to do many of the things I wanted to do. By my senior year of college I was resigned. I figured this was my set point, and accepted that it was something I would deal with for the rest of my life. But there was a fear growing in me, too: that my weight could hold me back from doing the one thing I had wanted to do since I was a child: become a doctor.

I was very self-conscious during my first interview for medical school. I was aware that I was the odd one out. Although those of us in the room were on an equal playing field intellectually, I stood apart on the visual field. I knew that if I was going to be taking care of patients I was going to have to do something about my own health. It was during this wait for my interview that I decided to make a change.

It was my last semester of college. I decided to push myself and

try something that I had failed at so many times before. I completely changed my diet and began exercising much more. By the start of medical school, I wanted to be the one in charge of my own health so that my patients would accept whatever advice I dished out to them. I lost 30 pounds by the start of my first class. Though this was a huge accomplishment for me, I still felt out of place at orientation. Clinically, I was still obese.

I hated that word.

I planned to keep pace with my new and improved lifestyle, but the rigor and routine of medical school made it a tough journey. I had difficulty managing my time and stress, and found myself slipping back into old patterns. Although I had lost another five pounds the first few months of school, I was right back up there by Christmas. It was time to reboot my whole routine and try even harder. It helped that I was also beginning a course about nutrition, metabolism and weight management. I started managing my time more effectively and getting back to the routine I had found so effective in the past. I started my race and won. Now, over a year later, I have lost 50 more pounds and am pushing 80 in total. My BMI is 23.

My experience gives me a unique perspective when I am talking to patients with medical problems that are directly related to their girth. I understand. And it is from this knowledge that I can begin the talk, and help them on their own road to good health.

“You should really try to eat healthier and exercise more” is advice that an increasing number of Americans face hearing whenever they visit their physicians. Patients have grown to expect this conversation about their weight every year when they schedule their physicals, and if they are anything like me, they dread hearing those words every time.

Weight loss is often seen as a simple solution to a complex problem. Diabetes, hyperlipidemia, hypertension and many other diseases can be prevented or at the very least diminished by changing a patient’s diet. For many physicians, lifestyle modifications are the first of line treatment for many metabolic diseases. At the end of an appointment, they may present their patients with pamphlets on proper diet and hand them worksheets with tips on exer-

cises they can do, asking them to follow up in a few months. When patients return with no change in their weight after three or four months, physicians automatically assume that the patients were noncompliant. Let me tell you first hand, you aren't going to find a patient who wants to be overweight, and they have probably tried more than once to bring their weight down. Chances are that they became frustrated and felt hopeless at some point in the journey, and the physician's reaction to their failed attempts is not helpful.

Over the past decade there has been increased attention paid to trying to "solve" the obesity epidemic. We as a nation have been inundated with weight loss products, fad diets and television shows and articles about success stories: Individuals who have lost hundreds of pounds. The media hype creates unrealistic goals for people struggling to lose any kind of weight. Television shows that show radical transformations week to week make it seem so simple that people wonder: "Why can't I do that?" It only increases their frustration.

As physicians (and physicians-to-be), we are often unaware of the burdens becoming healthy and losing excess weight impose. Sure, diet and exercise will help you lose weight, but are patients aware of exactly how much their lifestyle needs to change to start seeing results? Obese people are told to get 30 minutes of exercise at least three or four times a week by physicians, and another recommendation is that a person should be taking 10,000 steps a day. Does anyone really know how many 10,000 steps a day is? If not, I strongly suggest getting a pedometer and trying it out for a week. If you are like me, you will be very surprised; walking for 30 minutes at least three or four times a week will get you nowhere near the recommended 70,000 steps per week. And yet, a patient will try walking a few times a week and see no real difference and become frustrated and give up. This is not for lack of trying on the patient's part.

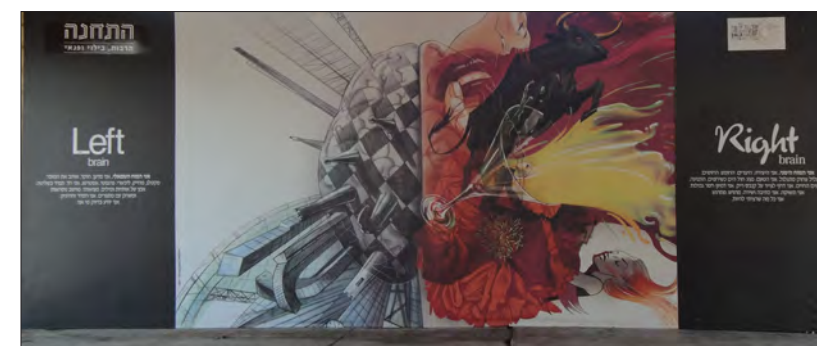
In addition to the difficulties of exercising, physicians often expect too much from patients when it comes to their diets, often making suggestions for radical changes that the patients are not ready for. The new calorie restrictions seem doable to the physician – limiting portions, cutting out fat and sweets – but it is quite a large shift for patients. They may restrict their diet for a few

days or even weeks at the physician's direction, but soon foods that were strictly off limits will start to creep back into their diet, and, frustrated with their lack of results in the first few weeks, patients will ultimately abandon it.

You have to wonder why physicians don't treat weight loss the same way they treat diabetes. When a patient comes in with the first elevated A1C, the physician doesn't throw everything but the kitchen sink at him or her in terms of treatment, but instead tries to control the disease with one medication, then adds another and another as necessary. Why isn't the same done with a diet plan? A physician can suggest that a patient first cut out sugary drinks, then after a few weeks try eating more whole grains and then eventually replace red meat with more lean proteins.

What can we do to facilitate healthy change? I had a moment in my journey when I realized I was actually making progress, progress that I had never seen before. The exact moment came when my educators, a group of physicians, began asking me how I was able to make the change, and I saw the looks of surprise on their faces when I told them I had followed a simple prescription: Eat healthier and exercise more.

Justin Rosati is a second-year medical student at the Hofstra North Shore-LIJ School of Medicine.



Left Brain, Right Brain

SARAH BAYEFESKY

Sarah Bayefsky is a second-year medical student at the Hofstra North Shore-LIJ School of Medicine. This picture was taken in Jaffa, Israel.



Obscure Path to Wellness

RAHMAT BALOGUN

Rahmat Balogun, DO, is a second-year resident in internal medicine at North Shore University Hospital and LIJ Medical Center.

Forgettable Us

It is Friday. I am sitting in one of the side chairs at my dining room table. I press down hard with the heels of my hands and slide them back and forth along my khaki-covered thighs.

Take a deep breath. Breathe.

I stare out the picture window at the overcast day and at the passing brown minivan. I see that, as usual, my neighbor's Suburban is parked facing the wrong direction.

You are wasting time. Stop procrastinating.

There are three items on the table in front of me, lined up like ducks in a row: my cellphone, the cordless house phone and my prepaid phone calling card. I have not decided which phone I will use for this call. Nationwide calls are included in my cell plan, but I think I get better reception with the landline. If I use the landline, I have to use the calling card because I have a regional calling plan and my phone company has an extremely limited interpretation of the word "regional." Only those calls within my area code are unlimited.

This call is to an out-of-state number, so I will run up the landline bill. My husband always complains and threatens to get rid of the landline, but I want to keep it. My landline worked during the northeast blackout of 2003, after Hurricane Irene when I lost power for two days and after Hurricane Sandy when I lost power for nearly two weeks. All of those times, the cell service was practically nonexistent.

Stop thinking about the landline. Make up your mind. Just do it. It doesn't matter which phone you use. The call will be short. Just make the call.

My hand wavering, I finally pick up the cordless phone and get a dial tone. I enter the access number, press "1" for English and enter my PIN. And then I enter the home phone number of my husband's 92-year-old French stepmother, Yvonne, who is living alone in central Florida.

As the phone continues to ring, I can imagine her getting up from the wingback chair in the living room and shuffling across the white tile floor in her beige Isotoner ballet-style slippers. I grit my teeth and hope she won't answer, or at the very least not fall on

the way to the phone. Maybe she is with Ricardo, the guy from her church whom we pay to take her to the grocery store and church.

You are pathetic. Grow up. You have to speak to her to remind her. Again.

And then I hear her little thin voice with its charming French accent – “Hallooooo?”

“Hi, Yvonne, it’s Lorraine. How are you?”

“Still alive.” She laughs as always with this remark. “And how are you?”

Fine, I tell her. And then I go down my usual list of questions and conversation starters: how is the weather, has it rained recently, did Ricardo take her to church last weekend, how is her little Schnauzer-mix dog, Lola, did the pastor at her church come back from his summer vacation? I tell her that my husband is fine, that my children are fine, and no, it has not rained in New York this week. And then I get to the purpose of the call, which is to remind her that we are coming for a visit.

Please remember. Just this one time. Please remember this one time. Just this one time.

As usual, her response to this information is full-fledged shock: “What?! You are coming?!” I sigh. I feel as though I am stuck in a movie, the one with the guy who cannot remember anything.

“Yes, we are coming. On Saturday. Next Saturday. The sixteenth. In eight days. Please put it on your calendar. I sent you a letter last week. Did you get it?”

There is no response. But I know what she is doing. She is removing the church calendar from the refrigerator and flipping through it.

“Did you put it on your calendar?”

“Noooo...”

“Please put it on your calendar. Saturday. The sixteenth.”

“But when will you arrive?”

“Probably around noon. Maybe a little later. Our flight gets into Fort Myers a little before 10:00. It depends how quickly we can get the rental car.”

Could you please stop talking? Just keep it simple. What does she care about your rental car? You are giving her too much information to process. Just give her a time you are sure of. If you show

up a little early, it’s not a big deal.

“Well, you must tell me what you will have for your breakfast.”

“Don’t worry about breakfast. We will take you to Publix when we get there.”

“But you must tell me.”

“We are easy, Yvonne. Banana, cereal, yogurt, milk.”

“I use skim milk, so if you do not use that, we must get something else.”

If nothing else, Yvonne is always the gracious hostess. After a brief discussion about yogurt – plain versus fruit and low-fat versus nonfat – I say goodbye and press the END button. I place the phone gently on the table. In three days, I will make the same call.

Memento. That’s the movie. This is like Memento. Please let her remember next time.

Lorraine Mesagna is a student in the MFA in Creative Writing program at Hofstra University.



Chairs on the Mountainside

BARBARA HIRSCH

Barbara Hirsch, MD, an endocrinologist and partner at North Shore Diabetes and Endocrine Associates, is a clinical assistant professor of medicine at the Hofstra North Shore-LIJ School of Medicine. She holds a master’s degree in narrative medicine from Columbia University.

Renovation Day

It's hard to imagine
there are sick people here
trying to sleep or
manage pain
pitched to the whine of a power drill
pounding with hammers
pulsating from jagged wounds in
perfect time with saws

or queasy people
sipping clear broth in this
clear-plastic-sheeting metropolis
finely coated with dust.

Down the hall
high-speed fans send
acrylic vapors,
displaced with the rest of us,
to permeate the space.

But there are sick people here,
sick enough for
stinging indignities.
At the desk
a stealth stench
mingles with paint
assaults the senses
settles on medical records.

Elizabeth J. Berger is studying for a master of science degree in narrative medicine at Columbia University, where her primary focus is self-care for health professionals. A para-rabbinic and multi-faith chaplain, she completed her training in clinical pastoral education at North Shore University Hospital.

I know
there could never be
an optimal time for
this but it's
a circus here
a three-ring circus
a frenetic netherworld
where mere wants for
small improvements
cannot yield to each other.

They swear all the
work will be
done in a day.
Inhale. Exhale.

Here comes my lovely
respiratory lady
doing her laps
wheeling a walker in
incremental inches past
whole contents of rooms and
walls lined with
tiptoed clinicians
sucking it in
to let her pass.

Then they all round on
in concentric circles,
widened now with the
mundane arrival of the
maintenance man
on his ride-on polisher,
orbiting the floor with just enough
rhythmic predictability to
convincingly cinch the farce.



Flow

ANDREW NG

Andrew Ng is a second-year medical student at the Hofstra North Shore-LIJ School of Medicine. In his free time, he enjoys slacklining and playing the mandolin, but not simultaneously.

NARRATEUR

This is my first wedding. I had the privilege of photographing the beautiful events of the day. I did my homework in preparation for the wedding. One photographer blogged about the joy of capturing the second the groom first sets eyes on his bride. How clichéd, I thought. But there I was, watching and waiting for this moment.

Snap.

Before the vows, I took a photo of this bouquet, lying in wait on the bed.

Snap.

There have been several moments in my medical training that are indelible and lasting, like a wedding, or a photograph.

The toddler who lies on an exam table, her arms waving happily like an infant's. Her coughing and choking don't seem to bother her. She is blind. In the picture, standing next to the girl, is a strong, smiling woman. Her mother. She is smiling even though her daughter's asthma has put a stranglehold on her throat. She is smiling as she recounts her daughter's medical history with Ring 22, a chromosomal abnormality. She is smiling even though at home she also tends an older child with severe autism. Her positive nature, her love, heal the child (along with a good dose of albuterol).

Snap.

I am drawn to medicine because of the trust that develops between doctors and their patients and caretakers.

Today, I am entrusted to collect memories of another sort.

Ann

Ann was a healthy and active child who grew up in a loving family, first in Brooklyn and then in Queens. Late in high school, Ann first felt the joint aches and body pains. There was also the malar rash that would eventually help doctors diagnose systemic lupus erythematosus, or SLE. In the late 1960s, this was not an easy diagnosis to make. She married and began teaching third grade in the Bronx public school system. Her disease seemed to take a back seat in Ann's early adulthood; she was healthy except for several miscarriages. Ten years after the couple took their vows, Ann delivered a healthy boy.

A year later the family moved from a Bronx apartment to a house in the suburbs. Ann ran her husband's chiropractic practice. They loved watching their son develop into a young man. It was a good life. But by the time her son was in college, Ann was increasingly breathless. Even climbing the stairs was difficult. She took her concerns to her doctors, and then a range of specialists. The conclusion was the Ann had idiopathic pulmonary fibrosis and pulmonary hypertension with pulmonary artery pressures near triple digits. These numbers were higher than any of her doctors had ever seen.

She would eventually need supplemental oxygen around the clock. She battled constant fatigue. She lost weight. But her interests – she loved her camera – and her family and friends never took a back seat to her medical challenges. Doctors recommended clinical trials that would take her to distant cities. She said no. She wanted to stay close to her family. She was never one to complain. Instead, she chose to focus on all of the joys in her life.

Supplemental oxygen turned into CPAP, and eventually she would require nighttime ventilation at home via a tracheostomy. Ann's son, now in his mid-twenties, moved to the city and returned home on the weekends to assist in his mother's care. Ann's husband had given up his chiropractic practice years earlier and now served as her full-time caregiver. On occasion, their insurance company would pay for a home health aide.

Soon, Ann's lungs would no longer function independently and the ventilator was used around the clock. Ann's husband slept in a

single bed by her side, spending most nights tending to her every need. He was there to feed, to clean, to medicate and to adore her, no matter what. He was not one to complain, either.

There were his wife's coughing fits and frequent suctioning and the need to reposition her every hour or so. One time, a severe bleed in her lungs brought her to the intensive care unit and she was sent home with a new level of disability. There were other hospitalizations. Throughout it all, Ann remained mindful of her circumstances. She knew that things would be getting worse.

It happened on a Sunday. Ann summoned her husband, son, mother, brother and sister-in-law, their grown children and their children's children to her bedside. She was calm and controlled. One by one, she hugged and kissed them and let them know what they meant to her. In her way, she was saying goodbye.

I was in that room. I was Ann's nephew. Three days later, my uncle called me. "It's almost time," he said. Over the years, I had listened and offered advice as a doctor, not just as a nephew and godson. Now, I asked if I could join them in the last hours of my aunt's life. My uncle said yes. I got in my car for the hour-long trip. I was feeling a mix of trepidation, responsibility and dread. I knew my aunt. She'd already said her goodbyes and this was not about repeat expressions or retreat.

I arrived at her local emergency room on a clear day in late fall. My uncle and cousin were there and so was Ann, sitting up on the hospital gurney, hooked to her home ventilator. A medical student was just completing the history and physical. The student was told that her new patient had increasing shortness of breath.

My aunt smiled at me and accepted a hug. She'd been waiting too long. "Why isn't my bed ready yet?" she indicated to me through writing and body language. My role now making sense, I worked with the hospital staff to get her into a private room. I picked up food for my uncle and cousin, knowing it would be a long night. The time in the emergency room dragged on. Few words were spoken, hands were held intermittently and patience wore thin.

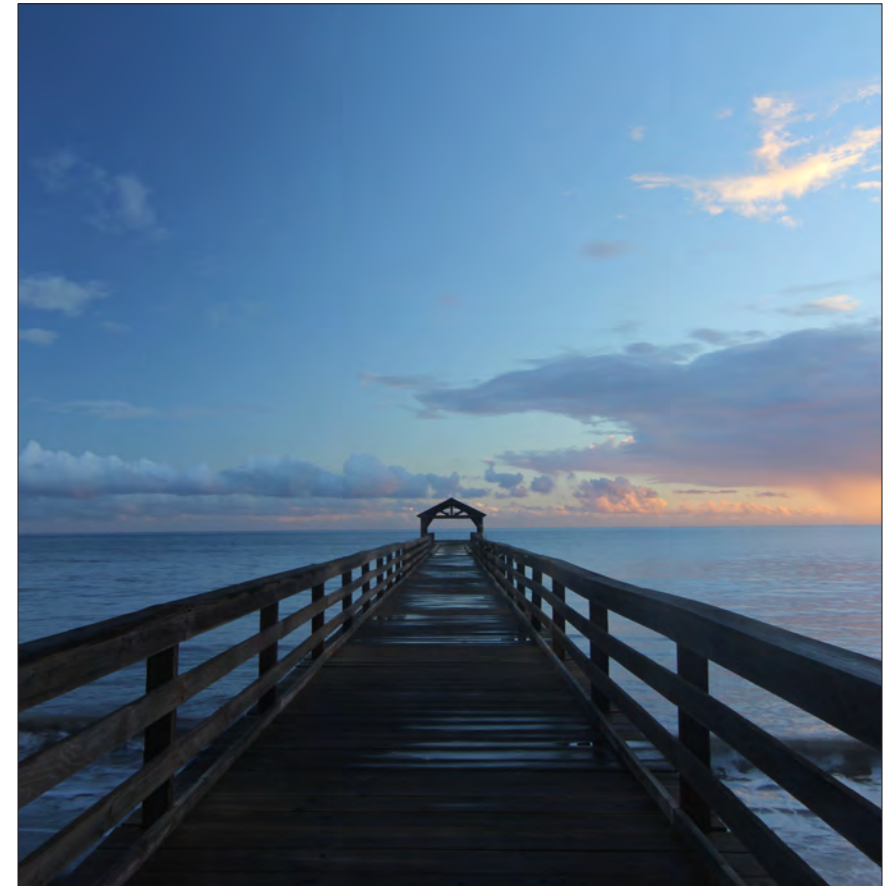
Finally, she was moved upstairs. I watched the sun setting over

the foothills. What a metaphor, I remember thinking. Her doctor arrived a few minutes later. The nurse set up an IV and prepared an injection. Her doctor explained the plan and my uncle asked a few questions. Everyone understood Ann's terms.

The sedatives in the IV were taking effect. Sensing my uncle and my cousin wanted to be alone with Ann, I left the room. The ventilator settings had already been changed so Ann could breathe on her own for the first time in over a year. I saw the medical student from the ER. She was standing by the nurses' station, crying. This was her first patient death, I was told. It was only two weeks into her medicine clerkship. I welcomed the diversion of sitting with and comforting her and explaining all that had preceded that day. We talked about the profoundly important role we play in the lives of patients, who sometimes are our loved ones.

Years later, my feelings about the circumstances of my aunt's death remain complex. I was never asked for my opinion about the timing or the arrangements. I never spoke with her doctor or the hospital about the plans before that day. I was asked simply to assist, to help, to witness, to make smooth and to provide comfort. In the end, this is what my aunt wanted. Her death was consistent with her life – clear, planned and under control. As a loving nephew and physician, I am grateful to have been able to fulfill my dual roles with reverence and compassion.

Andrew C. Yacht, MD, is chief academic officer and vice president of academic affairs for the North Shore-LIJ Health System, and associate professor of medicine and associate dean for graduate medical education at the Hofstra North Shore-LIJ School of Medicine.



Serenity

SAILAJA AKELLA

Sailaja Akella, DO, is a fellow in child and adolescent psychiatry at North Shore University Hospital and LIJ Medical Center. This picture was taken in Kauai, Hawaii.

Beyond the Phantoms

About a year ago, I noticed a change in my vision. It wasn't a blurring effect, or trouble seeing blackboards in the classrooms, or an inability to read street signs. No, it wasn't the need for a new eyeglasses prescription. It was nothing of the sort.

I first noticed it while driving. It was early into the fall semester of my senior year as an undergraduate. This was my fourth year adhering to a schedule that was wearing thin: morning classes, work, home. Professors. Bosses. Bed. It sometimes felt as if there was nothing in between, except the rare, obligatory hangouts with old friends.

The drive to the university each morning at 10:00 rarely changed. I often thought that I could simply get in the car, close my eyes, and my Jeep would drive itself there.

My attention often wanders as I drive, especially when the route is familiar. On that day, as I cruised along the Northern State Parkway, I gazed up into a spotless blue morning, not a cloud in a sky that seemed to stretch out infinitely. Empty, blue space.

Except it wasn't empty. Little particles, like hollow translucent balls, seemed to drift around the sky. They reminded me of the orbs commonly seen in photography. You know, that illusion that occurs when dust passes by the lens – the thing crazy people on ghost-hunting shows call “spiritual residue.”

These orbs would drift away whenever I tried to look directly at them, and my eye-darting game was endangering other drivers. I rubbed my forehead and assumed that I was overtired.

When I noticed them again on the car ride home, I grew nervous. As any type 1 diabetic can tell you, a change in vision does not bode well. So when I arrived home, I stood on the front lawn and just stared up at the sky and the flickering shapes that floated throughout my vision. What the hell were they? These ghostly objects seemed menacing. It was the way they lingered in my peripheral vision, the way they darted away when I looked directly at them. It was as though they contained some terrible secret.

As I entered the house, Mom was holding a plate over the stove as my father, brother and sister talked about their quotidian experiences. I heard Christine complain about her class of sixth grade

students – “I might just kill Dylan one of these days” – while Dad pulled out the martini shaker. I threw my keys on the coffee table and started walking up the staircase.

“Matt?” my brother called.

I stopped midway. “I have a headache. I'm going to lie down.” I kept walking without looking back.

That night, I took out a blank sheet of computer paper and hunted the spots in my eyes. They'd appear and disappear with alarming irregularity, and there were so many of them. Instead of writing my 10-page research paper on the uses of gothic structure in *The Castle of Otranto*, I played the WebMD game. You know, the point-and-click adventure often ending with terminal cancer or congestive heart failure.

“Cobwebs drifting in your eyes? Click here.” The first diagnoses indicated that my moving orbs were nothing more than eye floaters: a benign, common occurrence in near-sighted individuals. Almost everybody has them by age 70. Some people observe them at a younger age, however, and I like to think of myself as an observant individual. Perfect.

But... diabetics! “Click here to continue.” Floaters can also be a symptom of retinopathy, that horrible little complication of diabetes that results in blindness. I closed the laptop and slid it away. *Blindness.*

I called for an appointment with my ophthalmologist the following day. As always, there was a seven-day wait. I could have asked for an appointment sooner. I could have explained that this was a medical emergency, but my mouth refused to say the word “emergency” over the phone. That seemed too definite, too scary. Besides, they were most likely floaters, right? No cause for alarm. No need to tell anybody.

The days passed in a haze. I don't like to think of myself as paranoid, but when going blind is a possibility, all logic is out the window.

When driving, I'd watch the orbs instead of the road. When people spoke to me, I'd half-listen, eyeing the phantoms, which danced around their faces. I skipped several classes, called in sick

at work twice, didn't go out with friends. It got to the point where I simply dreaded communication with anyone.

The night before the appointment, I woke from sleep convinced I couldn't see. *Blindness*. I turned on the lights, and I squinted at corners of the room. Yes, I could see. I could. It was just dark.

As I lay there, cold and wide-eyed, the phantoms gathered. They whispered their secret: "This is why you've been going to the ophthalmologist for yearly visits. This is why Dr. Greenfield asks if you've had blurring vision. This is why. This is what it's been leading to. You're a diabetic. This is inevitable."

Dr. Shih runs her office like a factory: a well-managed factory, but a factory nonetheless. She is the only doctor I've ever had who boasts an MBA degree on her business card. Dr. Shih is short, kind, professional and incredibly energetic. As I walked in, I watched her sprint by to her next patient. I am not kidding; she was doing a solid 20 miles per hour.

"So, why the early appointment?" Dr. Shih asked.

"Changes in vision." I explained the orbs and watched her smile fade.

"Okay, we'll run some . . ."

"Is it retinopathy?" I asked.

She paused, and the silence seemed to contain a mix of "you're one of *those* patients" and "maybe." Her actual response was professional, as always. "Well, there was no bleeding in your retina when you were here last January, so it's unlikely a drastic change would occur so suddenly. But we'll check the options. All of them."

The tests took three hours. Apparently there's a technician's rule that says: "Keep everything a secret." After numerous look-here's and don't-blink's, I gave up asking how I did. "I'm just a technician," they'd say. "Your doctor will go over the results with you."

This not knowing was the worst, so I forced myself to pay attention to my surroundings because focusing on myself and my eyes for another minute might just kill me. I arrived at one conclusion during that endless period of observation: every other patient was approximately 110 years old.

In each of the waiting rooms, I sat among a group of antique people whose voices blended into a long wail: "How long do I have to wait? This is ridiculous. I've been here all day." As I walked the halls, I passed an endless number of shuffling souls – many with canes and walkers – and

they muttered disgruntled curses under their breaths. One woman bumped into me and then yelled "Excuse you!" when I tried to apologize. They were a creaking, cranky band held together by a strong sense of disapproval.

An hour later, when I walked into a room for test number six (a peripheral eye exam that I was sure I'd fail), a young technician breathed a sigh of relief. "Thank God. Young blood." Her statement seemed to correspond with my thoughts about the other patients.

I followed her instructions and stared into a large white dome, clicking a button every time a light flashed in the corners of my vision. In the middle of the test, a 110-year-old man walked in. "Am I in the right place?" He was wearing a patch over one eye.

"Who are you looking for?" the technician asked, pausing the exam.

"The bathroom."

She let out a sigh and showed him the way.

As I left, she handed me a paper. "Bring this back to your doctor." I took the slip. "Your peripheral vision is normal, honey," she said.

"Thank you," I replied, grateful she had broken the technician's vow of silence.

"Everything looks good." Dr. Shih explained that the phantoms were nothing more than ordinary floaters, but I sat there uncertain whether or not to believe her.

"Are you sure?"

"Absolutely."

"Really?"

"There's no bleeding or symptoms of retinopathy. Just ignore them."

Ignore them?

Dr. Shih sensed my trepidation. "Well, I shouldn't say that," she corrected herself. "Floaters can pull on the retina and cause a tear or detachment, so there are three things to watch for: a sudden flux in floaters, flashes of light or a curtain descending down over your peripheral vision." She counted these three symptoms on her fingers, as though they were part of her performance. "These are

early signs of a detachment, so call immediately and I'll refer you to a retina specialist. Otherwise, the floaters are normal . . . healthy, even."

Healthy? If I were to see a curtain falling over my eyes, I would certainly be calling. I thanked her. She said to come back in a year for my normal checkup.

I'd be lying if I didn't say I was excited by the news. I wanted to throw a party, to welcome myself back to reality. But I couldn't. Instead, I felt had to make peace with a handful of people for acting so strangely – for ignoring calls, for not showing up when I was expected. As I grappled with this, the euphoria of my good diagnosis wore off.

So I didn't say anything. I walked a little faster, smiled a little more – nothing too noticeable. But over dinner the night of the diagnosis I couldn't help it.

"Mrs. Webbins pulled Dylan out of class today," Christine was explaining. "Now I have to go in for a conference with his parents. Early. At 6:30, because that's the only time *they're* available for a meeting." I heard the clink of the ice against the metal martini shaker.

"I had my eye exam today. Completely normal."

"Oh, that's great," Mom said, with the enthusiasm of a shrug.

"Good," Dad murmured, carefully adding the bitters to his martini.

Mark kept eating.

"Nice," Christine said before shifting the conversation back to Dylan.

That was it. *Great. Good. Nice.* I knew if the results were any different, these people would be the first to offer advice and consolation. They'd rush to my side. Perhaps that's why I didn't want them to know in the first place. But, I was normal, so the discussion of my eye exam was over with three words.

It was time to move on, to rejoin the world.

"Wait, what?" I asked my sister. "You have to go in at 6:30 *in the morning* because they can't make time for their own kid?"

"I know, it's bullshit."

I reentered my routine with renewed appreciation for the or-

dinary. The drives weren't quite as tedious, the lectures suddenly seemed more interesting and work seemed to pass quickly. I was me again, and I struggled to understand why I had lived in such fear for seven days without letting anybody know. But I suspect we all struggle to overcome our phantoms, whether they are visible or not.

The floaters are still present – even now, a year later. If I stop and look, I can see them, and I know that they're not going away. They float, they swarm, they dance. They linger in my vision as a little reminder of how easy it is to get caught up in myself and ignore the people around me.

Matt Paczkowski is a student in the MFA in Creative Writing program at Hofstra University. His work has appeared in Devilfish Review and Spittoon magazine. Matt also writes articles for his website, Review Hub Central, and he is currently working on a novel.



Little Bee Eaters

SCOTT ELBERGER

Scott Elberger, MD, MPH, works at the Bethpage Urgent Care Center and in his spare time travels to places teeming with wildlife.



Memory of Summer

JOLANTA BARBARA NORELLI

Jolanta Barbara Norelli is a second-year medical student who is also pursuing a PhD at the Hofstra North Shore-LIJ School of Medicine. She is founder of the Art and Medicine Club. Her paintings and photographs have been featured in galleries in Brooklyn and Upstate New York.

This Is Lucia – Leave a Message

The voice is clear and fluent. Youth and energy are in her tone. The speech modulates, moving easily and smoothly over syllables. Her brain runs like a well-built engine. Concepts from cortex integrated with memory and hippocampus, flavored with cheer from amygdala seamlessly linked to temporal lobe: Broca's area is an eloquent spokesman for the neural network.

This was Lucia.

One year ago, there was pneumonia. Standard antibiotics failed to halt the bacteria's smoldering progression. An alert pulmonologist determined why. Bronchoscopy and PCP peeled away her secret – she was HIV+ and had never told her family.

Her mother's face was blank, like night without stars. Dark. I talked about AIDS and vulnerability, of antiretroviral choice and reconstitution, of rebuilding health and dreams, about longevity and love. On and on I prattled. Lucia's questions were technical, detailed, but distant.

Follow-up office visits were pleasant. She was doing well. She felt fine. She appeared healthy. Then lab results documented everything but wellness. There was progressive immune destruction and galloping virus.

I called her and spoke to her recorded voice: "This is Lucia – leave a message."

My message was delivered with calm desperation.

She called me back. Lucia continued to say that she felt well, but her immune system was imploding. I tried to stop pleading. Haunted by so many deaths from the early years of AIDS, I tried to bite my lip and swallow my words. I wanted so much to explore her youthful denial. "I feel fine," she said pleasantly.

Her mother's call came late in the afternoon. Something was wrong with Lucia. She was confused. She could barely speak.

Lucia looked fine in the emergency room. She could blurt "no" when asked about pain, but even that one syllable required focused effort. Her widening eyes screamed. She understood what was happening.

Brain imaging revealed the specifics: progressive multifocal leukoencephalopathy, or PML – the destruction of brain tissue by

reactivation of the otherwise trivial JC virus. Microbes that lay dormant now hunted, attacked, maimed.

The office visits are different now. Her mother is by her side and is her daughter's voice. Lucia's small and scattered syllables imply paragraphs of grief.

She takes HIV medication now. That disease has been halted. But can neuroplasticity fix her devastated temporal lobe? Can effort and prayer rewire her broken Broca's neuropil?

Alicia Keys is her favorite singer. I print out lyrics and ask her to read. She is unable to utter a single word. Her eyes moisten over the unpronounced lines:

"It took a brave, brave girl to try . . ."

"Don't be surprised if I talk a little louder . . ."

"It's just a brand new kinda me."

The voice on the answering machine, recorded months ago, is clear and fluent. Will my message ever be answered?

Bruce Hirsch, MD, examined his first patient with AIDS one year prior to initial reports of the condition (but did not realize it until two years later). He practices infectious diseases at North Shore University Hospital and LIJ Medical Center.

Cranial Orbits

One summer's night, stepping from scrubs to wooded ambit, I ran while my mind flickered with the lick-kick of incensement. Legs straining forward, mind straining back, the gossamers breaking, farewell over my heated knees.

While my mind flickered with the lick, kick of incensement I tried to temper my tempers, suspend the patient's life in gold hues. The gossamers – breaking farewell – over my heated knees, into pieces. I left them and ran on.

I tried to temper my tempers. Suspend the patients. Life, in gold hues. . . I was not a surgeon, not stitching up tattered hearts ripped into pieces. I left them. And ran on and on into the moss-kissed abyss that is the night

I was not. A surgeon, not stitching up tattered hearts, ripped to heal things burned and scarred, stifles the pain that runs on and on. Into the moss-kissed abyss that is the night, I followed the verdant thought-promise of healing sick.

To heal things, burned and scarred – stifle the pain. Run on, stepping from scrubs to wooded ambit, I ran, I followed the verdant thought. Promise of healing. Sick legs, straining. Forward mind, straining back.

Brittany Davis is a first-year medical student at the Hofstra North Shore-LIJ School of Medicine.

A Selfless Gift

Another day he was closer to death
but still greeted everyone
who entered his room with a smile,
said “please” and “thank you,”
asked us how our days were going
when it was our job to ask him the same.

He rarely complained,
though his body was ravaged by pain,
took meds more often than food.
Even in sickness, he lit up the room.
He wanted to be strong for his mother,
he’d tell us when she wasn’t around,
was more of a man in his 14 years
than many men I knew.

One afternoon there were no more days
to look forward to, no more days he’d struggle to smile
when someone walked in.
We all felt empty as the room he was last in
before he left us. Even in his absence,
he left behind something
that touched everyone fortunate to have met him –
hope.

Salma Siddique, DO, is a third-year pediatric resident at Cohen Children’s Medical Center.

The Listening Ear

I talk, he talks right over me
I write, he clenches his teeth
I prescribe, he doesn’t believe me
I read, but miss the gist underneath

He’s dying, I say come back
He’s thinking that I don’t care
His family waits in the lobby
His heart hovers mid-air

(I am the other half of reason)

Something is breaking in between
Bound to burst
Unless one of us acts –
There is the burden
There are the facts
I take a minute, he starts to relax

Christina Kachinoski is a student in the MFA in Creative Writing program at Hofstra University. She is a graduate of the New York University Surgical Technology program and hopes to meld her passions for both fields.

Graduation Day

Almost 15 years ago, I was sitting where you are today. My parents were so proud. They had always wanted me to become a doctor, and graduation actually fell on their thirty-third wedding anniversary, an unplanned but perfect gift.

On that day, in 1998, pediatrician Bruce Downton gave the commencement address. He spoke eloquently about his early dreams of becoming a doctor while growing up in the outback of Australia. “From that limited horizon,” he said, “I knew nothing of the world at large, let alone the world of medicine.” His words resonated with me. Not so long ago, in graduate school at Berkeley, I’d also felt I was a world apart. I’d been desperate to get out of the ivory tower and join “the real world.”

Dr. Downton offered this piece of advice: “Keep a simple value system. Work out what things in life you care about, the beliefs you hold near and dear, and stick to them. You are about to go through a most tumultuous time,” he said. “What are you willing to accept? What are you willing to fight for?” I wrote it down in my Palm Pilot: *Figure out a value system*. A few weeks later I flew to New York to start my residency.

I’d never really thought about a value system because I’d been too busy trying to figure out what to do with my life. My twenties were a turbulent time. I studied physics as an undergraduate. Then I applied to law school. I eventually went to graduate school and got a PhD. All the while my parents encouraged me to become a doctor. My mother often said she wanted me to become a doctor so that people would stand when I walked into a room. Even after I entered medical school, I was too busy to think about “values.” I had to get through pathology and pharmacology and the boards. I had to do well in my clinical clerkships to get a good residency. I was too busy worrying about whether I had what it takes to be a doctor to think much about a value system for the way I would eventually practice.

Now, I realize that medical school was just beginning of my education. The real learning in medicine doesn’t happen in the classroom or in the library. It doesn’t even happen at the bedside. It happens in your head and in your heart. It is how you process the

rich experiences to which you are exposed that determines the kind of doctor you will be.

What kind of doctor do you want to be? This is a question you will have to answer in the upcoming years. And you will have to do it with the knowledge that people will place outsized expectations on you and our profession. There is often a disconnect between how the lay world views our profession and how we experience it from the inside.

I remember a weekend when I was on call in the ICU as a second-year resident. I was rounding with Abe Sanders, our attending. Dr. Sanders was a portly, avuncular man with a mischievous grin. Despite the miseries of the ICU, he always maintained a relentlessly upbeat manner.

It was a brilliantly sunny day, perfect weather for sailing. Midway through long, protracted rounds, Sanders called us over to a window. He pointed down at a sailboat on the river. A man was standing on the deck, looking up at the hospital. He looked about Sanders’s age, though fit and tan. He was holding a drink, and a party was going on onboard. “See that guy?” Sanders said. “Do you know what he’s thinking?”

We were standing in a vented patient’s room. The alarms were going off. No one ventured a guess.

Sanders said: “He’s thinking, ‘I should have been a doctor!’”

As medical professionals we have a more nuanced view of medicine than the man on the boat. Medicine accommodates all types. Neither we nor the profession we practice is perfect.

A decade ago, the economist Julian Le Grand spoke to this point. He developed the idea that public policy is grounded in a conception of humans as knights, knaves or pawns. Knights are motivated by virtue. They want to make the world a better place. Knaves are selfish. They desire to extract as much as possible for themselves. Pawns are passive. They follow external rules and regulations rather than an internal code of conduct.

In a 2010 essay in *JAMA*, two doctors, Sachin Jain and Christine Cassel, applied these concepts to medicine. Knights, they wrote, practice medicine to save and improve lives. The best thing

government can do is get out of their way and let them do their jobs. Knaves, on the other hand, put their financial well-being before their patients' well-being, often ordering tests for personal gain. Government needs to guard against their malfeasance. Pawns are ruled by the environment in which they practice. The role of government is to incentivize them to do what is right.

The history of American medicine over the past half-century can be viewed through this lens. In the halcyon days of the mid-twentieth century, physicians were thought of as knights. We were among the most highly admired professionals, comparable to astronauts and Supreme Court justices. It was a period when life expectancy increased sharply, aided by triumphs of medical science. There was the advent of the polio vaccine. Then, scientists developed the heart-lung bypass. Depictions of physicians in the media were overwhelmingly positive, almost heroic. Doctors were able to trade on this cultural perception to achieve an unusual degree of privilege and influence.

Though he practiced in a different country, my maternal grandfather was a knight. As a boy in India, I used to watch him at work in his iodine-stained clinic on the ground floor of his home in New Delhi. Through the living room window I'd spy him examining patients with boils or sepsis. He looked so distinguished in his three-piece suit and spectacles. His patients showed up at all hours, even during meals, and always without appointments: first come, first served. My grandfather was deeply proud of his knowledge. He fancied himself a mainstay of the community. He received fair compensation from those who could afford to pay, and provided charity care to those who could not. Though it was a different time and place, this picture of a physician matches well that of the American physician knight.

I think we all still want to be knights. Most of us went into medicine to help people, not to follow corporate directives or to maximize income. No one ever goes into medicine to do unnecessary testing. But this sort of behavior is rampant. The American system today often seems to promote knavery over knighthood.

Having now been in medicine for the better part of my professional life, I can tell you that there are all types in our profession: knights, knaves and pawns. Most doctors are an amalgam of all

three. The question is, which type predominates in a person?

Today, the vast majority of doctors say that the overall morale of the profession has declined over the past five years. One reason, I think, is that we still want to be knights. We want to practice medicine the right way – but too many forces are propelling us away from the bench or the bedside. You must guard against this. How? By doing what Dr. Dowton told me 15 years ago: Figure out a value system and stick to it. Decide what kind of doctor you want to be. Identify what's important to you, what you believe in and what you will fight for.

For most of us, our professional compass begins and ends with our patients. In surveys, most physicians, even the dissatisfied ones, say the best part of their job is taking care of people. The humanity of our profession is something no one can take away.

What I savor most about being a doctor is the gentle surprises. Once, when I was a resident in the ER, I was called on to perform an abdominal paracentesis on a young woman with alcoholic cirrhosis. I set up my instruments carefully: catheter-tipped needle, rubber tubing, plastic buckets. When I was ready, I cleaned the woman's belly with iodine soap. Then I pierced her abdominal wall with the catheter and started filling the buckets.

Midway through the third bucket, I got paged. "Whatever you do, don't move," I said to my patient, whose breath still smelled of alcohol. "I'll be right back." I told the patient, "If the catheter comes out, I'm not going to put it back in." She nodded. I left the room and stopped by the nursing station. "Just keep an eye on her while I'm gone," I told a nurse.

I was away for only a couple of minutes. When I returned, the buckets were upturned and liquid was puddled all over the floor. The catheter was out, and the drain tube was coiled uselessly on the tiles. "I told you not to move," I said angrily, tiptoeing across the mess. "I didn't," my patient replied unconvincingly. "A man came in here and had a seizure on the buckets."

Exasperated, I stalked out to the nursing station. "I thought I asked you to keep an eye on her," I said to the nurse.

"I did," the nurse replied, "but then a man wandered into the room and had a grand mal seizure on the buckets."

These are special moments! These are the moments you should

savor when you are interns and residents. It is a complex and intimidating world you are about to enter: intensely human, with villains and heroes, successes and failures, oddities, mysteries, absurdities and profundities. In the next phase of your education you will face exhaustion, pressures and moral conundrums the likes of which you've never experienced. You will have to make compromises to get through it. We all did. But figure out now the things on which you won't compromise. You can go down many paths in medicine. You will have to decide which one yours will be.

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Floral Sunrise

ANDREW MENZIN

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Emergency Contact

The procedure was unexpected.

She had arrived a week before, unaware of how a simple half-hour visit could pull out the few remaining earthbound roots of her life. Of course, she had suspected something was wrong, but she was convinced it was psychosomatic, not actually physical. And now, seven days turning into seven centuries, she knew it was both.

She told no one the news. Her mother would have broken down and her father would have turned to stone. She knew their routine well at this point. She was too embarrassed and afraid to tell her friends; those few who remained were too valuable to risk losing. So her silence became her armor protecting her from the world. It was hers, and so it was her burden to place between her shoulder blades, only hers.

She figured she already carried the burden of loss, so what was one more stone? When he left, there was no reason that made sense. She had put on her brave face at first, stonewalling the anguish smashing against her skull. She often wished he had died. Grieving is easier when the loss is not voluntary.

Her blank, brave face had been a permanent fixture since his departure. Outwardly, she was shut off, impenetrable, distanced, but not broken. Inwardly, she suspected she was losing it, slowly spiraling down, down, down to some bottomless dark place. So at first, she attributed all the symptoms to her despair. It was when she saw the full moon through the skylight, and she thought back to the last one, that she realized what was happening.

The doctor, a silk-haired man with eyes that did not betray his pity, had delivered the news softly. He had waited in silence as she took it in. The options were discussed factually, emotionlessly, carefully. She was left in the room when the doctor went to grab brochures. She studied her surroundings. The walls were painted a warm-toned purple, and there were pictures of flowers. The doctor's stool was close to her right knee. Pressed into the corner opposite her, as far from her body as it could possibly be, leered the empty guest chair.

She scheduled the procedure for the following week. She thanked the doctor. She spent six nights staring out at the skylight until the first hints of dawn broke through and exhaustion brought the bliss of unconsciousness.

On the seventh day, she drove to the hospital. She parked but had no recollection of the drive. She walked to the right floor, maneuvering deliberately toward the reception desk. There, some voice that was not hers gave her name, and some hand that seemed to be hers but that couldn't be handed over her insurance card. She found herself sitting down, choosing the chair closest to the door. Across from her, a couple waited. They sat by the window, silhouetted by the sunlight. Their hands melded into one, and they leaned their heads against one another's. Every piece of them fit perfectly together. She looked away.

The doctor brought her into a room and told her what to expect during and after, even though he had done so a week before. He asked her if she had anyone with her to take her home after the procedure. She replied that she was alone and planned to take a cab back and get her car another day.

The doctor looked at her, quiet. He placed both his hands over hers. "Did you tell him?" he asked.

She was silent. Her face betrayed nothing.

After several moments, he said he would get the hospital's car service to take her home and asked her to have a family member get the car. She promised she would and then signed the consent form. He looked it over, scratched something on the page and left her to change.

Several minutes later, she was on the operating table. Naked except for the thin paper gown, she stared up at the fluorescent lights. An odd noise escaped from her throat after the mask had been affixed to her face. As a burning rose in her throat, a gloved hand slipped into hers. It was the same hand that had written its owner's phone number into the emergency contact space she had left blank. As she slipped into unconsciousness, she realized she was finally crying.

This story was inspired by an interaction I had with a patient during my first visit to Labor and Delivery. A young girl arrived for a dilation and curettage procedure. She was alone, and when she was positioned on the table, she began to cry. The physician held her hand until she was unconscious, and I was left wondering what had brought her all alone to this point. This is my tribute to her and other women in similar situations.

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Mist

EDMUND MILLER

NARRATEUR

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Swan's Way

Swan: This is not a new problem. I've had it for years. It just seems to have gotten worse.

Doctor: What do you think is making it worse?

Swan: I think it has something to do with maturity. For a long time I just accepted it. I don't think I really knew it was a symptom or a problem, you know what I mean? It just seemed like me. But now that I've turned "that age," it hit me that it was not right. I mean, I think it's time I did something about it.

Doctor: So, for the first time, you recognize your inclination toward ducks as a symptom, something abnormal, and you want to do something about it?

Swan: Yes.

Doctor: You want to eliminate this inclination?

Swan: Definitely. After all, I am a swan. I am not a duck. It just doesn't make sense that I want to be with ducks all the time. Of course, I fight it. No other swan knows what I go through. I am pretty good at keeping it to myself. But it affects me. Often with others I find myself too quiet. Afterwards I feel I missed an opportunity to make friends. I know there is something wrong and it has to do with this duck thing, but I can't quite put it all together.

Doctor: I understand. One way to approach this is to obtain an understanding of your background. Tell me a little more about yourself. What important things can you remember about your past? Does anything you can remember seem relevant to the problem about ducks?

Swan: Ducks? Ducks? My God! Yes! Why didn't I think of that

before? I am so stupid. It's so obvious. What's the matter with me?

Doctor: There is nothing fundamentally wrong with you. You are really quite a normal swan with a particular problem. It often happens that problems in the past escape our recall and affect our lives outside of our awareness. Just relax and tell me what you remember that might be important.

Swan: Doctor, please don't think I'm foolish for not considering this before. It's all so clear now.

Doctor: Of course. Now tell me about it.

Swan: Don't be surprised, doctor, but I was brought up by ducks.

Doctor: Your parents were ducks? Impossible! How can that be?

Swan: I was not really born from ducks. I was brought up by them.

Doctor: Oh. Go on.

Swan: Well, I don't know what happened to my real parents. I don't think anyone knows. All I can remember is that when I first awoke to the light of day, I was with ducks my own age.

Doctor: How did you feel about this? It must have been unsettling to know you were with ducks and not baby swans.

Swan: That's just it. I didn't know. I thought I was the same as they were. I thought I was a duck.

Doctor: I see. Very interesting.

Swan: That was not the worst part. My brothers and sisters, or, at least what I believed were my brothers and sisters, noticed that I was different.. They immediately began avoiding me and always put me at the end of the line. When I sometimes had trouble keeping up, they yelled at me and called me names.

Doctor: Do you remember any of these names?

Swan: One sticks in my mind. I think I will never forget it . . .

Doctor: Yes?

Swan: “Ugly!” Yes, they always called me the “Ugly Duckling.”

Doctor: That must have been very upsetting.

Swan: It was. It was. I was mortified. I didn’t know what to do. I cried to myself, and I always made sure they didn’t see me so upset. I thought they would pick on me more if they knew. What’s worse, I believed them. When I looked into a pool of water I saw that I was very different. I didn’t look like the rest of them at all. I truly believed that I was a duck and that I was ugly.

Doctor: Well! Didn’t your adoptive parents do anything to help? Didn’t they recognize that you were not a duck, try to find your real parents, or protect you from your adoptive siblings?

Swan: No, nothing. They ignored the whole thing. All they did was swim about in the pond as if nothing was going on. I think they knew I was around, but they acted as if they didn’t. Looking back on it, I don’t think they wanted to face up to the full meaning of my presence.

Doctor: Why, do you think? Any ideas?

Swan: Yes. It all seems so clear now. If they recognized the problem, they would have had to explain my presence. I don’t know if they had any part to play in my being in their flock. Perhaps yes, perhaps no. If so, their guilt would be obvious. In any case, they would have had to tell their own ducklings. Then it would have been necessary for them to deal with the conflicts between us. You see, my parents were quiet ducks. They avoided problems altogether. I really can’t understand why they had ducklings at all. They would have been just as happy flying south in the winter and north in the summer without the added worries of a family. It wasn’t just that I was too much to deal with. Everything was too much to deal with. They were simple ducks, without sophistication. They couldn’t handle a duckling that was really a swan. So, they denied it.

Doctor: Hmmm. Good. Go on.

Swan: They were not all bad. They saw to it that I was fed. I was never neglected as far as my basic needs were concerned. Despite their psychological blindness, they were good parents when it came to the necessities. I . . . I . . . I can’t believe I’m crying. It’s wonderful. I haven’t cried in years. Real tears!

I do love my parents. But I’m angry at them, too. Why didn’t they understand what I was going through? Sure, they didn’t reject me, but they sure as hell didn’t get involved in my emotional needs either.

Doctor: So, if I understand you, your inclination to be with ducks comes from this early experience. You were, as a child, a duckling, so to speak. Upon growing up your transformation into a swan went very far toward helping you overcome your antipathy toward yourself as an ugly duckling, but never removed your feeling that there was something wrong with you. The conflict was so great in your uncon-

scious that you suppressed your past, lived as a swan, but never felt right about it. All of this was complicated by your ambivalent relationship with your adoptive parents. You loved and hated them. Your memories, only vaguely remembered but mostly in your unconscious, drew you toward and away from the members of your family. These conflicts made you both want to be with ducks and, simultaneously, stay away from them to sustain your own true identity. The problem in accepting yourself as a swan was complicated by your realizing that your original swan parents rejected you. It must have been very difficult for you, all this?

Swan: It was! It was! This is all so wonderful! I'm so grateful to you, doctor. I would never have figured all this out by myself. Thank you.

Doctor: Do not thank me. You did the work. I have only been your guide. We must now see if the symptom disappears.

Swan: I may be wrong, but I think it will. I realize that what happened to me was an accident of nature. I hold no one to blame. I feel I understand it all.

Doctor: I think you understand a great deal; but we are not through. Do not be impatient. There is still more to do.

Swan: We are not through?

Doctor: No. We have just begun.

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Abstraction in Anatomy

ANDREA TUFANO

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Every Chance in the World

In this Verizon commercial, a doctor is working in a rural village in Southeast Asia. He's listening to a little girl's heart, and then he pulls out this crazy Star Trek-looking scanner attached to his smartphone. The scanner sends something to the computer of a doctor in America (well, she has an American accent) whose writing appears on the screen. She points at fancy equations on a board. Then, a voiceover proclaims that with cloud technology and telemedicine kids can have "every chance in the world."

This is a lie.

A part of me wishes it were true. If only we could build a program that teaches people to maintain these fancy smartphone scanners, gets them reliable WIFI and service for a cheap price, connects them with doctors who see this project as a job and an avocation and manages to actually obtain and provide the care that the doctors prescribe. But interest wanes and money dries up. When the smartphone eventually dies, what have we actually done to this community? We have made them reliant on foreign aid and in awe of the power of American doctors, so no one trusts the local nurse. We have forced on them a perspective of the world where their country is third class and will never amount to anything. We have given them the idea that somewhere along the way some other powerful and rich country will come along and fix everything.

In Cambodia, a country I know well, imagine you are a young mother with a newborn baby boy. You're a typical rice-farming family. You work in the fields from dawn to dusk. Your family makes 200 dollars a year. Your diet is mostly rice and dried fish, so the baby was born a little underweight but otherwise healthy. You try to breastfeed around the clock but you can't bring the new baby into the fields with you.

At home, the younger children watch the baby and when he gets hungry they feed him rice porridge you made in the morning. At two months old, the baby gets a cold and cough. Your family lets you take the bike two miles in ankle-deep mud to the local health center. The visit costs 25 cents, and they provide medication. You bike home.

A month later the baby gets sick again, and then again, and

again. Each time is worse, and the nurses at the health center notice the baby is not gaining enough weight. They try to teach you about breastfeeding and weaning the baby with nutritious foods when the time is right, but you don't even have a market in your village to buy vegetables. The baby stops gaining weight, and you notice the color of his hair is changing. His belly seems swollen. He cries all the time. Your family is worried, and you decide to take the baby to the special children's hospital in the nearest city, which is 20 miles away.

You use the bike (again) and then wave down a passing pickup truck. The ride into town costs two dollars and takes two hours. The police stop the truck twice to collect bribes. You wait all day to be seen at the hospital. The care is free, but the small clinic is packed with mothers and their crying children. You return home at night with some special baby food. The baby eats well and you try to breastfeed more often. It seems to be working, but then the food runs out. It's been months since the last harvest, so there's no more cash for visits to the hospital. Planting season begins again. The baby dies.

I've seen this story play out hundreds of times, and it makes me angry that we as human beings can't come together to find a solution. It makes me angry that politics and economics play a role in the fate of these people and then companies like Verizon use only a part of their stories to sell their products. My phone company is Verizon, but I'll never let these commercials fool me into thinking that my daily cell phone usage is saving lives.

Helen Pu is a first-year medical student at the Hofstra North Shore-LIJ School of Medicine. After graduating from Bowdoin College with a bachelor of arts degree in neuroscience, she spent two years in the Peace Corps in Cambodia, and she also worked for Women for Afghan Women.

Astoria Collision

I'm not even sure what happened. I just saw the white Lexus pull a fast U-turn, emergency flashers turned on, and then the shattered remnants of a broken window fall to the street from a dilapidated white minivan parked on the west side of 31st Street in Astoria, right below the N-Q trains near 34th Avenue.

Then I saw the shadow. And the bike. And it all started to make sense. The driver had hit the biker and then something had smashed into the window of the minivan. I didn't see the collision, only the horrible aftermath. Should I stop? A lonely shadow slumped over. Yeah, I should definitely stop. This doesn't look good. I should really grab my stethoscope and try to do my best to help.

I scrambled for the stethoscope that I had casually thrown onto the back seat half an hour earlier, after my 12-hour shift. Just an hour ago with that same stethoscope I was listening to the chest sounds of a child with bronchiolitis at Cohen Children's Medical Center.

I found the biker lying on his back. He was Hispanic, with sinewy skin, maybe in his thirties or forties. I saw the laceration just below his left eye, where most of the blood was coming from. There was a lot of blood. A surgeon might guesstimate 250 mL, or a can of Red Bull.

Then I saw it, and I didn't even realize what it was at first. About a fourth of the upper hemisphere of his cranium was smashed in, exposing the dura mater and broken fragments of skull.

Don't think about that. Just help. Remember your training, go through the steps. Scene safety, BSI.

But I did neither of those things. I immediately jumped to c-spine stabilization. There was another man speaking in Spanish to the victim. "Sir, call an ambulance. Did you call an ambulance?" I must've asked four times. I had the stethoscope around my neck. A crowd had formed around us and they looked at me as if I knew how to save him. All I had was a stethoscope.

Okay, stop thinking about them, stick to your training.

I had c-spine, so next came ABCs. First airway. I convinced a

nearby man to hold c-spine stabilization while I assessed the victim's airway. "Abre su boca," I said. He opened his mouth. Thank God. He can hear me and he understands.

Focus. Stop thinking, go through the algorithm.

Help is on the way and he needs to get to a neurosurgeon as soon as possible. I looked in his mouth. He had bitten off a chunk of his tongue, and there was blood. Lots of blood, and gargling noises. Shit, how do I clear his airway while maintaining c-spine? And I didn't have suction. "Spit!" I commanded. Then I spat to the side in an effort to more clearly communicate my meaning. He spat.

"Stay awake! Look at me, sir." I stared into the eye that wasn't completely mashed into his face, his right eye. And he was looking to the left. His right eye was looking to the left and not at me. He was looking to the side of the lesion. Damn! He has brain damage and cranial nerve 3 is involved.

No time for thoughts like that now. Do what you can to help.

B – breathing. His airway was clear even though there were bloody secretions in his mouth. I needed to keep him awake so he could keep spitting. Now listening for breath sounds. He was breathing. And his lungs sounded clear. I listened to the lower airways and didn't hear much. Pneumothorax? Hemothorax? Why can't I hear any breath sounds? A train rattled overhead and I took a second to look around until it passed so I could hear breath sounds. I heard them over his scraped chest. At least I think I heard them.

Moving on, keep the airway open. C – circulation. Feel his pulses. He has a carotid pulse. He has a radial pulse. His systolic blood pressure must be at least 80. Okay, I have a plan. Keep his airway open. Apply direct pressure to his head and check his pulses. Help should be here soon.

Continue with the algorithm and everything should be okay. I hope.

"Noooo!" screamed a woman. Probably his mother, or sister. Or both. There were two women there who clearly knew the man very well. They were hysterical. I would be too if I had a loved one

whose skull looked like this man's. "Ma'am, please step back," I said. She didn't listen.

Okay, don't worry about that now.

The women threw their bodies over the man. "Sir, what's your name?" I demanded.

No response, and his breaths were getting more and more shallow. "Sir, *como se llama?*"

"Juan," he responded weakly. He heard me again. Thank God, I thought.

I can't remember the last time I thanked God for anything. Funny how He pops up at times like this.

Sirens in the distance – the ambulances were finally here. There were two of them. Both had *FDNY* on the sides. They pulled up, and one of the paramedics saw me. "Who are you?" she asked.

"I'm a medical student and EMT," I replied. "This man was hit by a car and his head was smashed against that window." I pointed to the white minivan. "His c-spine is stabilized but we need a c-collar immediately. His airway has bloody secretions but he is conscious and can spit. His lungs sounded clear but there may be decreased breath sounds in the right base. Please double-check. His systolic blood pressure is at least 80 because he has radial pulses. We need to get him on a backboard and transport as soon as we can."

"Okay," she said. "Go grab some gloves," I looked down at my hands, which were covered in the man's blood. At that point, the paramedic and EMTs welcomed me as part of their team. The only thing that mattered was that we care for this patient as best we could.

We maintained the airway with a modified jaw thrust. I led the count to move the patient to the backboard, as another paramedic from the second ambulance wrapped Juan's head. "We're going to get you to the hospital, Juan. And they're going to give you the best care."

"Okay," he said. He was still here with us. We got him to the back of the ambulance. The EMTs and paramedics on duty had taken over.

The two women who knew the man were asking me where they

were taking him. I asked the medic, and she said, "Presbyterian on 68th."

"You ride in this ambulance, you ride in the other," I told the women.

The ambulances pulled away. One EMT and one police officer stayed behind to question the driver. He willingly admitted to hitting the man. "I didn't see him," he said.

A fair response, but I still hated the driver in that moment.

Juan was en route to the hospital and someone else was speaking with the police as a witness. As I turned to leave, a bystander thanked me. "No problem," I replied as I got into my car, stethoscope in hand.

What had happened didn't really hit me until I was about four blocks from my apartment and looked down at the steering wheel. The hands that were driving my car had blood all over them. It was almost as if I were returning to myself after an out-of-body experience. My stethoscope had blood on it. The cuffs of my jacket and parts of the sleeves were soaked.

I was so mad. Why wasn't he wearing a helmet? Or a reflector vest? But why am I blaming the victim? Why wasn't the driver paying attention? White Lexus – must be some reckless Wall Street behavior. The driver was well dressed. Designer jacket. So many thoughts flooded my mind as I walked through my front door.

I never found out whether the man survived, or whether I did anything to help. I sure hope I didn't do anything to make the situation worse. I wished I had a full name or information to follow up, but I didn't. I implemented an algorithm to the best of my ability, but did I actually make a difference? I'll probably never know, but I continue to be comforted knowing that I stopped and did all I could. I slept well that night.

Good Night

He could be hard, an unflinching man of business. In the end, many would recall his generosity that built with glass and mortar and filled halls with generations of sick young people and doctors and nurses to make them better. He had little patience for those who were not sick. Uncompromising, he demanded that the people around him work hard and be strong. That is how he felt he had made it big in the way of money and big in the way of building places to mend the body.

He came from little but acquired much – some thought too much for any one man. But he understood that his riches were handed down not by companies or banks but by a higher power. He gave God credit for his success and for the money in his pocket.

He had three daughters he adored, but the man held only one woman in his heart, and in the end his was a singular love story. At home, the man, a tiger in the world of business, was not feared but led like a cub to warm milk.

In the end, it came down to the collapse of the wife's veins under the weight of intravenous medicines and the inexorable growth of the tumors in her lungs that could not be halted.

It was well past midnight when doctors knew the end was coming. She was no longer conscious of the world around her. Her body was shutting down in the same hospital that her husband had helped build. Her doctor could not decide whether to call the man, well into his eighties, so that he would know she was in her final hours in this world. In the end, he made the call.

The man rose from their bed, put on his winter coat and headed out to his car for the 20-mile ride. It would be another few hours before the sun would peek out over the horizon.

The corridors were sleepy and quiet. He came into the room and stood over his bride. She had been in a coma for days. A few minutes went by. He was thinking about their half-century together.

"You are beautiful," he said to his wife. Later he would not be sure if he had said this in his head or aloud. Her eyelids fluttered and then opened. She looked at her husband, who showed no surprise that his comatose wife was staring right at him. "I thought I told you to go home and get some rest," she said. "Go home."

"Darling," he said, "I just forgot to say good night."



Your Favorite Thing

WILL PATTEN

Will Patten is a first-year medical student at the Hofstra North Shore-LIJ School of Medicine.

Howard Kerpen, MD, directs the Lorber Center for the Advancement of Medical Education at LIJ Medical Center and is the Lorber Professor of Medical Education and professor of medicine at the Hofstra North Shore-LIJ School of Medicine.

Pas de Deux

My little lion man roars.
His infant tongue grunts a throaty yelp.
I feel tingly, flushed, and unsettled,
While he is cold and scared.

We lie down skin to skin,
Like lizards needing each other for heat.
Our bellies start to rise and fall in synchrony.
He opens his right eye and heads for my right breast.

Tickle tickle at my nipple then deep rhythmic suck suck.
An electrical discharge runs down my leg, and my toes
tense up.
I relax and release a long “Ah,”
While my dexterous monkey chirps an “Eh.”

We travel through a looking glass,
Transcending earth down a wondrous rabbit hole
Leading to a frothy fountain of youth.

While my little black water snake extracts from one mound,
I feel a fiery tug at the other.

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Patient

doctors
that heal
that feel
when patients fall
and patience fails
and flails
at life gone stale

patient doctors
that hold
that hear
when patients frail
and harrowed
health hollowed
cry, to be whole

patient doctors
that help
that hug
when patients reach
to be freed
to scatter
hurt and fear

in need
of
patient doctors

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a hand and upper-
extremity specialist at
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sity Hospital and LIJ
Medical Center.*



Purple Mountain Majesties, Los Flamencos

ALAN SLOYER

Alan Sloyer, MD, is a gastroenterologist and clinical attending physician at North Shore University Hospital. His camera has been to more than 65 countries and his photos have been published in the New England Journal of Medicine.

An Introduction to Death

It was cold and dark when I climbed out of bed that Saturday at 5:00 a.m. to work my first EMT shift. I was excited. I was anxious. I was ready for anything, or so I hoped. I had been prepared, but I didn't know what to expect.

As I drove to the dispatch site, my anxiety grew as I thought about the wisdom a seasoned EMT had shared with my class several weeks earlier. In brief, his message was this: When you enter the healthcare profession you relinquish the luxury of looking the other way. You can no longer protect yourself from the messier side of life – or death.

I arrived with enough time to wade through a sea of parked ambulances in search of my own. When I spotted it, I introduced myself to the EMT standing next to the vehicle. He opened the front door for me to jump in. Because I was dressed in the uniform of an EMT, he assumed I was an experienced member of the team and not a rookie. The uniform, I would learn, conferred an expectation of the possession of knowledge and certain skills to my coworkers and patients alike.

At that point in my training the only skill I confidently possessed was how to put on the uniform. So I reintroduced myself, established my credentials as novice medical student/novice EMT, climbed into the back of the ambulance where I belonged and waited as the rest of the team assembled.

It was while I was sitting there that I realized that I was no longer just me – a scared 21-year-old only weeks into medical school being thrust into the “real world.” Now I was part of something bigger. To passersby and individuals on the road, I had become “the ambulance.” “Thank goodness the ambulance is here!” a frightened family member might say when I arrived at the scene. Or “There goes another ambulance. I wonder what's going on?” someone might say as we drove by. Regardless of how I might feel on the inside, to outsiders I was a healthcare professional and part of a team that arrives on the scene and is a beacon of hope to those in distress.

While ruminating about this I suddenly realized that the ambulance was moving, and moving quickly. Then the siren was blar-

ing. “Where are we going?” I swiveled my neck around to question the EMTs in front. “911. Cardiac arrest,” I was told.

I looked at my watch: 7:15 a.m. While most of my classmates were still asleep, I was barreling toward the home of a person on the brink of death. I fought the instinct to jump out of the vehicle and run in the other direction.

When we arrived at the scene, the front door burst open and a man of about 70 showed us in. He walked us to the room where his 96-year-old mother appeared to have lived for months, possibly years. I felt odd, walking into a stranger's home with no introductions, no pleasantries, just a hand wave into a small, stuffy, dimly lit bedroom.

On the bed lay a slight old woman, weighing no more than 100 pounds. Her wrinkled skin drooped around her open mouth, and the deep creases on her forehead and around her closed eyes made her look angry rather than peacefully asleep. I stood staring at her, unconsciously maintaining a distance of several feet from the bed, when I noticed one of the EMTs trying to get my attention. I moved closer at his urging and placed two fingers on the loose, warm skin of the woman's neck, making my first contact with a patient in my medical career. There was no pulse.

The patient's DNR meant that there was nothing to be done. I looked up at the man who had opened the front door, the patient's son. His hand rested on his furrowed brow as he looked at his dead mother. My heart leapt into my throat and I had to fight back tears. I had never seen a dead human before, and I certainly had never seen a mother pronounced dead in front of her son.

I felt out of place when I looked into her son's eyes, imagining him taking care of her for years. I felt sad when I saw the pill bottles that cluttered the dining room table and the medical bills on the couch, evidence of his love for his mother and the sacrifices he had made to be with her and take care of her.

What right did I have to stand in his living room listening to the EMTs report back to dispatch while he quietly wept in the next room? I stood there trying to stay out of the way and also trying with great difficulty to maintain my composure. “You okay?” a

police officer asked – my poker face clearly needed some work.

“Oh, me? I’m fine,” I said, turning to face the wall.

“It’s her first time,” one of the EMTs said, gently putting a hand on my shoulder. I felt foolish for displaying cracks in the façade that just a few hours ago convinced an EMT that I was ready to sit in the front of the ambulance.

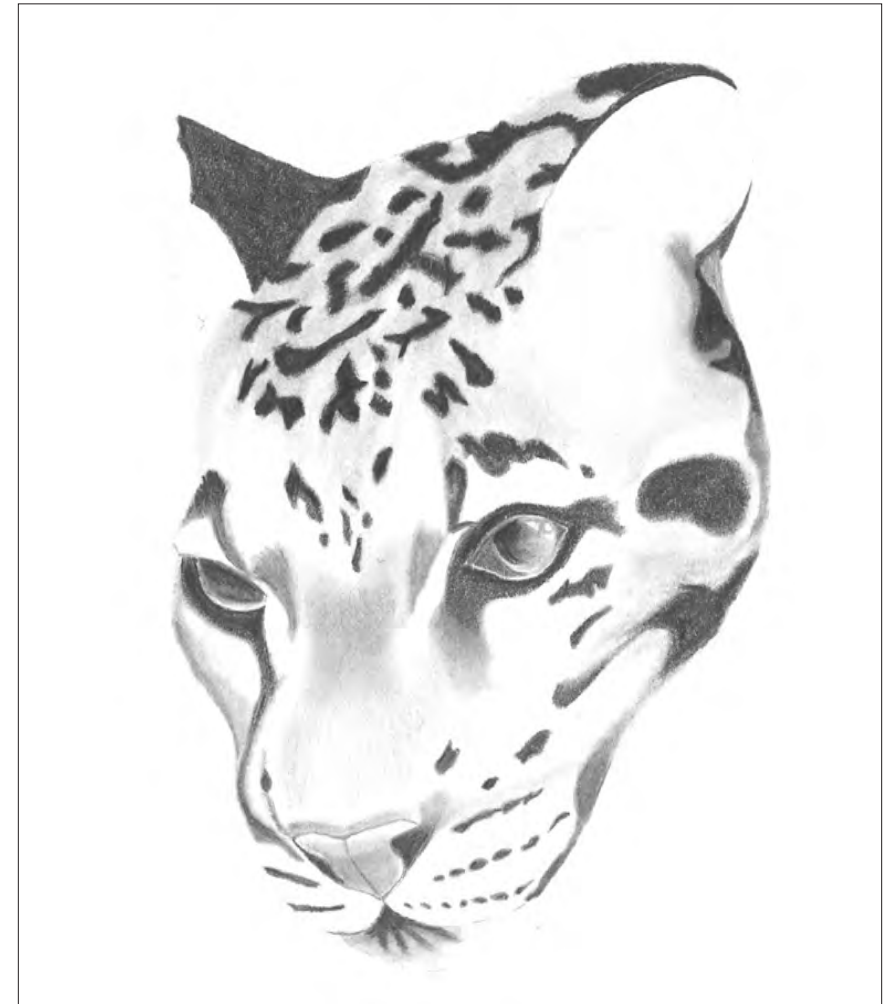
When arrangements had been completed and all phone calls had been made, we picked up our bags and made our way to the door. One of the EMTs said a few kind words to the grieving man on her way out. He stopped us, shook our hands and earnestly thanked us, even though we had not been able to help his mother. He thanked us for coming and for helping him to navigate one of the most difficult moments of his life.

When he shook my hand, I no longer felt foolish or out of place. In that moment, I wanted to thank him for allowing me to be a part of his life at such a difficult time. I wanted to let him know how deeply this first brush with death had affected me as a student and future physician. “Take care,” I said as I left.

While my first clinical experience in medical school was not the sterile hospital bedside encounter I had imagined, I truly am thankful for it. I am certain I will encounter death many more times in my career, but most likely these deaths will be of patients on hospital beds, far removed from their personal effects and anything that might link them to the lives they’ve lived. I have made a promise to myself always to bear in mind the people my patients were before they walked through the hospital or office door.

With only one-eighth of medical school completed, I certainly have much more to learn, but I will be grateful always for the lessons I learned that first day.

Dahlia Hassan is a first-year medical student at the Hofstra North Shore-LIJ School of Medicine.



A Cat

NICHOLAS PETIT

Nicholas Petit is a second-year medical student at the Hofstra North Shore-LIJ School of Medicine.

It's Just a Box

Jimmy smirks as he draws his cigarette to his lips, demonstrating smug satisfaction with his evaluation of the old ambulance. He is a young probationary firefighter in a ladder company that has recently taken possession of a new \$800,000 truck. The ladder truck towers over the little 15-year-old ambulance, its chrome gleaming brightly in the midday sun.

Like most firefighters, Jimmy has a disdain for the emergency medical services, a sentiment passed like a cherished keepsake from generation to generation. The old guard of the firehouse is represented by salty, timeworn men who came into the profession when fires were fought without self-contained breathing apparatus and when disagreements were settled with fists behind closed doors. Emergency medical services, a relatively new service provided by these 100-year-old fire departments, is often viewed as a tumor, consuming resources that could be better used on the “fire side.”

When I first joined the fire department eight years ago, I suspect I would have taken offense at Jimmy’s statement. His words denigrated my image of paramedics. The remark was inflammatory and hinted at the expendability and superfluity of the EMS.

But that was then.

Lost in reminiscence, I roll my cigar between my fingers and bring it to my lips as I squint to examine the scars on the side of the old ambulance.

Seven years ago, I was a cocky and inexperienced EMT-Basic, intent on proving myself to anybody who showed a semblance of interest in me. Like Jimmy, I mirrored – or tried to mirror – the toughened veterans of the firehouse. When the alarms sounded, they moved purposefully and unwaveringly, their faces lacking any suggestion of anxiety or excitement.

One day, I was pacing around the truck room waiting for a call when suddenly the bells rang out overhead. I bolted to the ambulance, trying to contain my excitement. My lieutenant hopped into the driver’s seat and notified dispatch of our response.

The voice on the radio replied, “Be advised, you are responding

to a working building fire with firefighters trapped.” The skin on the back of my neck tightened.

As the ambulance screamed through intersections and charged down the fire lane, I could feel my heart pounding behind my eyes. I became fixed on controlling my breathing. As we approached the scene, black smoke began polluting the blue sky in front of us and I became acutely aware that my foot was dancing in the wheel well.

The lieutenant threw the ambulance into park, and a soot-covered firefighter jerked open my door.

“Hurry up!” he barked. “They’re pulling one of them out now!”

My lieutenant and I charged around the back of the ambulance and unloaded the stretcher. Blankets tumbled off as we hopped over five-inch supply hoses that crisscrossed the wet street between hydrants and engines. As we approached the side of the house, a plume of smoke, like the steam from a screaming teakettle, spewed from a small basement window. A crowd of firefighters were face deep in the column of heat, tugging a body through the narrow opening. Moments later, the body was thrown onto our stretcher; I caught a glimpse of the raw, burned face of a boy younger than I was at the time. He was conscious and writhing in pain.

“Drive the ambulance!” my lieutenant ordered.

“I’m not a driver,” I nervously responded. I couldn’t believe how fast my heart was thumping. I wondered if I would pass out while driving.

“Figure it out,” he growled.

By that time, another firefighter had come up behind me and was yelling directly into my ear, “What the hell are you waiting for? Let’s go!”

I didn’t know where to go. I had no idea where I was or where the closest hospital was. A police sergeant ran up to the window.

“These two cars are going to escort you to the hospital.”

Great, I thought. How the hell do I drive with an escort?

“Let’s go!” screamed the firefighter.

I threw the ambulance into drive and picked up the radio, but I couldn’t figure out how to contact the dispatcher. Frustrated, I

chucked the radio across the cab and put my foot on the gas. The ambulance started to creep forward as a squad car charged past me, sirens blaring. I pressed the pedal harder, trying to catch up. The old ambulance slowly crept up to speed. The gas pedal was firmly planted between my foot and the floor and the engine was churning like an old steam engine.

As we approached the first intersection, the lead squad car stopped in the line of traffic. The officer was waving his arm outside the window trying to direct me to turn left. I had barely a moment's notice, so I slammed on the brakes as I took the turn. In my panic, I thought, *Jesus, I'm going to flip this thing!* In the rearview mirror I saw my lieutenant fall on top of the firefighter. I imagine he would have howled at me had he not been speaking to the hospital over the radio at that time. Another squad car blasted past, splitting the traffic.

By the time the hospital came into view I was breathing heavily with the window open. I didn't know how to back the ambulance into the bay, so I parked head in across two spaces. *I must look like the biggest idiot*, I thought to myself.

Suddenly we were swarmed by nurses and physicians who took control of the stretcher and rushed it into the critical care rooms. There the injured firefighter was whisked onto a hospital stretcher, still reeking of smoke in his filthy turnout gear, and we were crowded out of the room.

And just like that, it was over.

I lift the cigar up to my lips again and watch the cherry at the tip glow bright orange. It's a perfect summer day, bright and warm, with a pleasantly cool breeze blowing through the trees, sending dogwood petals floating across the skirt of the firehouse.

"What's up, boys?" roars ex-Chief O'Casey, who is washing his car at the firehouse. O'Casey is an enormous man with a bald head, a pierced ear and a big handlebar moustache. When he was chief, he was referred to as "Chief of the World," and everyone knew not to mess with him. When angry, he could be a terrifying person to be around.

Despite that reputation, O'Casey was known to be a loving husband and father, and a generous and caring person to his friends and neighbors. His family was the first in the history of the department to

have three generations active at the same time.

I suddenly have a vivid recollection of the first time I worked with Chief O'Casey.

Ambulances are frequently called to aid elderly people who have fallen. The calls tend to be very low-adrenaline experiences. But not this one.

I pulled up in front of a well-tended ranch-style home, with large, beautiful azaleas flanking the front door. An elderly man stood at the door, calmly awaiting our arrival. My partner and I walked to the stoop, not feeling any sense of urgency.

"My wife fell. She's in the bathroom," he said, and then he shuffled off into another room. He appeared unconcerned.

I walked into the bathroom, dropping my medic bag at the door. I looked toward the bathtub, and there I saw, in six inches of dirty water, a moderately obese elderly woman who had managed to wedge herself into the tub in a remarkably grotesque way.

"Help me!" she cried in a raspy voice. "Please!" Her head and shoulder were squeezed into the corner of the tub. Bloody water lapped dangerously close to her airway. The copious tissue on her upper back was obstructing the tub drain. Her right leg had a large avulsion that was fileted open, and her right arm, trapped behind her head, was angulated mid-shaft along the humerus, with ecchymosis speckled about the fracture site. To underline the urgent nature of the situation, we learned that she regularly took warfarin for anticoagulation. I began to consider the possibility of a subdural hemorrhage.

I didn't know where to start. It was obvious that she needed spinal immobilization, but her body was squeezed into the tub as if poured into a mold. I picked up my radio and asked for a rescue company to respond. I was beginning to wonder whether we would need to use a saw to cut the tub open. But there was nothing my partner and I could do on our own, so we sat beside her and reassured her.

Minutes later, we were relieved to hear the front door creak open, and a voice boom, "Where you at, boys?"

Chief O'Casey filled the bathroom door as he entered. "Whoa! What did you do?" he exclaimed when he saw the woman.

After some discussion, we agreed to try to maneuver sheets under the small of her back and then work them up and down her body to create multiple “handles” to lift her out of the tub. It was a testament to the EMS motto, “Adapt, and overcome.” Once three sheets were positioned beneath her shoulders, hips and legs, we assigned a fourth individual to try to hold the patient’s head stable. Chief O’Casey holstered, “On the count of three! One! Two! Three!”

The large woman was lifted straight out of the tub and immediately lowered onto a backboard next to it, where she was quickly packaged for transport. “Good work, boys,” said the chief.

I hopped onto the ambulance as she was being loaded in and began my assessment as the ambulance lurched forward. The patient hadn’t said much, so I tried to rouse her. She was breathing but was not responding to my questions. Her eyes were closed.

I lifted the lid on one eye and checked pupillary response with my penlight. I lifted the other eyelid. I was greeted by a large, fixed pupil.

I tap the ash off the stub of my cigar and take a puff of hot smoke.. Jimmy is busy texting some girl. The ambulance sits across the street, half-shaded by an old oak tree. It looks tired. I guess it is just a box, as Jimmy said, if you are inclined to view it in the most literal sense – a box with wheels.

But to me, it represents a trial by fire. It represents a sense of responsibility for another person’s life. It represents dedication and determination. In the eight years that I rode on that ambulance I was transformed from an impetuous boy to a man with a purpose.

As I walk around the firehouses now, I see all the new probationary members, eager to prove themselves. Kids like Jimmy. They rush to be respected and accepted. But that old ambulance has seen enough pairs of boots to know that actions speak louder than words. You have to earn your stripes.

I toss my dead cigar onto the grass.

“See you around, Jimmy,” I say. He gives me a nod and lights another cigarette.

I hop into the driver’s seat of the ambulance, with its familiar old-fabric-carseat smell and cheap plastic interior.

It feels as if I am home again.



Remainderman

DAVID MARCUS

David Marcus, MD, is chief resident for the combined program in emergency and internal medicine at LIJ Medical Center. His blog on emergency medicine, medical education and ethics can be read at www.EMIMDoc.org.

Michael Spigner is a second-year medical student at the Hofstra North Shore-LIJ School of Medicine. He is a paramedic in the Manhasset-Lakeville Fire Department. He is also a regional representative for the Emergency Medicine Residents' Association.

ICE

I love beautiful songs. I imagine they play in the background as I go about my business – like the opening scenes of a movie where, in the beginning, I am just another person. I am just an average woman but really we will find out that something special exists inside of me. The beautiful song says – look, even though she is just driving or studying or writing in her journal, there is something great and beautiful or introspective but extraordinary about her, and you need to know her story.

Yet maybe those are just own my grandiose desires. Escapism? Megalomania? God complex? Today was my first day of psychiatric ICE. Adolescent ward. And the whole time I was thinking – *I've been here*. High school only ended three agonizing minutes ago, right? I have had these feelings. I have relished the feeling of blood pouring down my arm and dripping onto the carpet. I have thought of the pointlessness of the universe and my life and the endless struggle. And I have thought of killing myself. Yet here I am, in medical school, and there you sit, a 17-year-old disaster with only half a foster family and the scary promise of adulthood in a few short months.

How did we turn out so different? How come I get to be on the normal side – the examiner side – and you get branded as the mentally insane? Foucault screams in my head of the perverseness and the eagerness of both the pathologizer and the examined. The mentally insane. I'm crazy, you say. A label to grasp at, reject, rage against, shove into people's faces to keep them away – a shield with which to protect yourself from the hurt and rejection that will inevitably come.

There you sit, raging against yourself and the world and the picture of life success sitting in the chair across from you. We feel a universe away from each other as I pause to scan the sheet of questions they told me to ask you.

And yet I see how much you love it here. A community of craziness. You are all fitting together and belonging and somewhere inside you may know it is wrong, but you love it. How did you end up here? What brought you in today? How different are we, really? You look at me and see the perfect stranger. I look at you and see

myself. I see the faces of my loved ones stalking halls like these after their own dark detours. And yet here I am in medical school. Aren't you proud of me for making it this far? I am healthy and blessed. I escaped hospitalization. You did not. What's the difference between us? That I am hidden and you are exposed? I do not understand why I did the things I did. And you have learned to repeat back a psychiatrist's definition of your special crazy.

We all want to be special. But for tonight I will just listen to this song and imagine that all of this stuff of life has a beautiful and broken and deeper meaning. That beneath my basal rhythm of wake, eat, school, gym, study, rinse and repeat, there is a mystery waiting to be unraveled. That something more exists and everything we have gone through just to get to this point has a purpose and a melody and it is beautiful. We are not that different.

Leah Stork is a second-year medical student at the Hofstra North Shore-LIJ School of Medicine.



The Engaging Patient

ABRAHAM AXELRUD

Chaplain Rabbi Abraham Axelrud, PhD, is a staff chaplain at LIJ Medical Center. He is also professor emeritus of the City University of New York. He has served as a U.S. Army chaplain and staff chaplain at Stony Brook University Hospital.



Spanish Doors

LOUIS POTTERS

Louis Potters, MD, is chair of the Department of Radiation Medicine in the North Shore-LIJ Health System and professor of radiation medicine at the Hofstra North Shore-LIJ School of Medicine.

NARRATEUR

Two Raincoats

In 1976, when I was a young trainee in obstetrics and gynecology on Long Island, I was assigned as an educational supplement to attend the Memorial Sloan-Kettering Cancer Center's gynecologic service in New York City for two months.

Soon after I began, I decided that hospital bedlam was well under control there. The staff members were exceedingly respectful of each other and the patients. The operating rooms functioned with optimal precision. Medical protocols were extremely well designed. And the care of the patients was superb.

Among several patients in my charge was an elderly, bedridden woman, a victim of a prolonged hospitalization. During our frequent but brief conversations, she always had an optimistic smile and a whisper of gratitude, despite her sallow complexion, her feeble attempts to shift herself in bed and her poorly healing abdominal incision.

A pleasant and attentive husband was always by her bedside. He seemed content to remain in her cramped hospital room, no larger than a prison cell. If he was not standing to gaze out the window, he would sit on the chair near her bed, often holding her hand. If he was sitting, whenever anyone entered the room, he rose from his chair to "stand at attention" as if some visiting dignitary had appeared. He did this each time I entered the room. One afternoon I observed him doing this when the sanitary engineer entered with his broom to do the daily floor sweeping.

Initially, I felt it proper to visit this couple to check on a new lab finding or if there was medical information to relay to them. However, knowing that prolonged hospitalizations may add to patient frustration and anger, harsh boredom, anxiety and melancholia, it became my self-imposed duty to visit them several times daily. On occasion I would do a "doctor gaze," an exceedingly brief stare with an air of feigned relaxation. (We were a stressed bunch.) Sometimes, I would just stand by the window with the patient's husband, saying nothing.

One day, the sun was creeping up on the Manhattan skyline when I entered her room. Her abdominal incision was badly infected despite the fact that she had received myriad wound lavages

and intravenous antibiotics.

I brought this finding to the attention of the attending physician, who then reviewed the antibiotic regimens, returning to the bedside several moments later with some capsules, several of which he popped open. He emptied their white powdery contents onto a sheet of paper, which he creased down the middle. He held the paper at an angle and tapped it over her belly wound. He had me continue this process four times a day. Within several days the wound had improved.

The day before I was to complete my tour, I found myself again at the window with my patient's husband.

What would I say to this couple tomorrow? I knew that I would miss my visits. Her husband began to talk about their life and how good he felt being in this small room with his wife. For the first time I noticed a row of tattooed numbers on his forearm. A glance at her arm confirmed the same. How had I not noticed before now?

He moved to stand in back of me. He was much shorter, and he reached up and put his hands on my shoulders. There were no words. There didn't have to be. He seemed thankful for my visits and my daily attention to his bride.

The next day, I entered the room for the last time. My smile was weak. I hadn't prepared my goodbye. The husband rose from his seat. My mouth was dry and I blinked my eyes, to fight back tears. I don't know why I felt sad, but it had something to do with the knowledge that their life together would be ending soon. She was very sick.

I moved close to my patient's bed. I bent down toward her chest. I could feel the faint beat of her heart, a butterfly. She whispered to the wind, wishing me a long and healthy life. She knew that residents rotated on and off the floor every two months and my time was up.

Her husband opened the closet in the room and pulled two new and handsome raincoats, one navy blue and one tan, off the wire hangers. Each had wide lapels and an attached belt. That was the style 35 years ago. He told me that he was retired from the raincoat manufacturing business and that each resident trainee got two coats on his last day of work.

I then realized that he had been measuring my shoulder width at

the window on the previous day. I accepted the coats. It was long before doctor-gifting issues became a subject of ethics discussions. I still felt uneasy taking them, because I knew that health-related personnel must always give and not receive, but I knew that refusing their generosity would have insulted them. It was their way of thanking me.

With two raincoats in hand and not a cloud in the sky, I left the majestic hospital and moved on to my next rotation.

The coats served me well throughout the seasons and the years that followed. Eventually, I outgrew them in size and style. They remained in my closet for decades. One day I noticed that my grown son was wearing one of the coats. It fit him well, but the material and linings were brittle with age. Again, it was time to say goodbye.

I think about this couple now and again, and I wonder how many raincoats of former residents still hang in closets, and what lessons they still teach.

For me, the raincoats stand as a reminder of the caring and the time we owe our patients. Decades later we don't remember the names of the medicines we ordered, but we do recall the wounds and the healing that took place when we leaned in and talked.

Howard J. Kraft, MD, is a gynecologist at ProHEALTH Care Associates in Lake Success and at North Shore University Hospital, where he is director of quality assurance in the Department of Obstetrics and Gynecology. He is also a clinical associate professor of obstetrics and gynecology at the Hofstra North Shore-LIJ School of Medicine.

Structure Lab

The pulse: the femoral, the brachial, the carotid. Arteries, large and small, traversing the body, navigating through the flesh. They are still now, motionless without heat, silent without their usual beat. The cadaver lies stiff and still and yet there are signs of life. Her story is mapped across her body, her flesh a topographical narrative telling of a woman's life. Her hip is bruised; her arms are pocked with needle marks. This, however, is a story not of pain, but of perseverance, a tale of continuity and consideration. There is pride in her carefully done nails, expertly manicured and painted. Her stretch marks speak of a mother, lovingly carrying a child. Her donated eyes and body convey a life of altruism that perseveres. There is a pulse, a life, a story coursing through this woman's veins.

Tamar Harel is a first-year medical student at the Hofstra North Shore-LIJ School of Medicine.



Make Me Special

MARC SYMONS

Marc Symons, PhD, is a scientist at the Feinstein Institute for Medical Research.

Monday in the ER

It's Monday night. We have a saying, "You don't know what it is to hate going to work on Monday until you work in the ER." Tonight is a really great night to generate stories. It's a terrible night to be a patient. Busy doesn't begin to describe it. The New York Stock Exchange floor is busy. Here tonight it's the fifth sign of the Apocalypse.

I'm in full crisis mode – sick patients to fix, scared patients to soothe, well patients to reassure, and I'm staring down a four-hour wait. This is one of those nights that I won't stop to eat, drink, sit or pee. I am running the entire shift just to catch up and see daylight. I am in a marathon.

It is then that the note arrives.

Paramedics have called a notification so that I can screen a pregnant patient for injuries before she's transported for evaluation in Labor and Delivery. An assault case, the run sheet says. This shouldn't take me too long, I think. She's a well-dressed black woman. She is calm. There is an ugly abrasion on her neck. She tells me the story of how she came to be here tonight. The story of how her teenage son punched and choked her, kicked her in her swollen second-trimester belly. I take it in without a pause, simultaneously examining her for significant injuries. She goes on to tell me how she criticized his girlfriend, how he'd been drinking and how he'd never been violent before this evening. Her exam is benign. I'm already mentally checking her out of my department when she says: "He got a gas can and splashed me and then went looking for a match."

I stop and turn to look at her. Her face crumples for a split second before her hands hide it from sight. I feel my eyes welling up, and I have nothing at all to say. Why this sudden jolt into sadness, into empathy? Was it not enough to hear of a son attacking his pregnant mother? Perhaps I'm recalling the many victims of acid burns and attacks on women by men in their own families in Pakistan and Bangladesh. Perhaps it's that the color of her skin is so similar to my own – a reminder of my loved ones, my tribe. Or perhaps it's purely that I hadn't really heard her before and needed to be jolted out of crisis mode.

I hold her hand. We're both quiet, and I blink back the tears, conscious of the other staff members in the room. It seems like minutes that we are in that silent pose. She takes a breath and looks up, controlled once more. They come with a wheelchair to take her to Labor and Delivery. The moment's over.

Just like that, I have to put it away. I walk out of the trauma bay and back into the chaos of the ER. The wait time is up to five hours now. Perhaps there will be time later for reflection.

Pinaki Mukherji, MD, is an emergency medicine attending physician at LIJ Medical Center.



The Healing Power of Love

JOCELYN GREENSHER

Jocelyn Greensher is a United States Naval Officer, a professional tattoo artist and a first-year medical student at the Hofstra North Shore-LIJ School of Medicine.



Fractions Within a Frame

JAY THAKKAR

NARRATEUR

Jay Thakkar, MD, is a first-year resident in family medicine at Glen Cove Hospital. He is Indian by origin, global by mind, an endurance athlete, a photographer, a singer and a compulsive foreign language-learner.

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Ocean

What makes an ocean beach beautiful? she asks. Maybe it is the geometry, he answers. If you went to draw it with a pencil and paper, you could start with a series of parallel lines inscribed horizontally across the paper, right to left or left to right. It doesn't matter, he says. It might, she says. One line would represent the boundary between the wet sand and the dry. I find that sad, she says. Several others reveal the action of the wind, which leaves behind small hillocks; these are nearer to the bottom of the work because they are closer and the conventions of perspective require this. Does this mean, she says with a frown, that objects of our desire that are close at hand are less worthy than those at great distance (and perhaps unattainable)? Then there is the line that suggests the shore itself, where sand and ocean meet. Artists draw this as a line but in reality there is no such single boundary. More lines cross the paper higher and higher, he says, or farther and farther, she adds, and suggest the surf and gradations of color that are infinite in number and therefore not possible to draw precisely. This is as it should be, she notes. Bisecting our field of view is the hard straight edge of the horizon, steel below and azure above. He suggests that there is, according to scientists, no such thing as a field of view because in fact our eyes see only a small patch clearly and the illusion of a field of view is the result of rapid and unconscious movements of the eyes. A cloudless sky occupies the upper half of our picture and of our field of view. It is not possible to draw a cloudless sky, he says. Because there is no line, she says, leaning closer.

Michael Grosso, MD, serves as medical director at Huntington Hospital and is an assistant professor of pediatrics at the Hofstra North Shore-LIJ School of Medicine.



Bubbles

CARLA PODGURECKI

Carla Podgurecki, MD, is a second-year family medicine resident at Glen Cove Hospital.

Submissions

Narrateur: Reflections on Caring is published by the North Shore-LIJ Health System and the Hofstra North Shore-LIJ School of Medicine. The medical journal seeks to publish high-quality work that reflects experiences in the practice of medicine and the learning that takes place along the road to taking care of patients. Themes should include health, illness, caring, and expressions of the human condition. The submissions are not intended to contain opinion or advocacy editorials. The journal will publish once a year.

Submissions are open to Hofstra North Shore-LIJ School of Medicine students, faculty, and staff as well as employees of the North Shore-LIJ Health System and Hofstra University. For more information on submission guidelines visit our web site at www.narrateur.org.



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